



**Refocus on Recovery 2012 conference
5-7 March 2012**

London, UK

researchintorecovery.com



**Institute of
Psychiatry**

at The Maudsley

**KING'S
College
LONDON**

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Welcome...

To the Refocus on Recovery 2012 conference. The conference is organised by the Section for Recovery at the Institute of Psychiatry and by Rethink Mental Illness. We hope that it will be of interest to anyone who wants mental health services to support recovery from mental illness, including mental health service users, carers, mental health workers, managers and mental health system leaders. The conference aims are to:

1. Increase the visibility of recovery research, including both the best international work and national and local studies.
2. Identify and explore concerns about the meaning, relevance and practice implications of 'recovery'.
3. Consolidate research collaborations and give an opportunity to develop new networks.

The conference showcases best-in-field recovery-related research, and provides an opportunity to develop new alliances with recovery champions. Several international key-note speakers are describing recovery-related innovations, and national research and service developments is being presented.

The four themes of the conference are:

Theme 1: Social rights and activism

How can an inclusive society and communities be fostered? What empowers people who experience mental illness? Do political and social activism increase citizenship? Do ideas of recovery, well-being and social inclusion help or hinder citizenship?

Theme 2: Peer-support: lived experience and role models

What is recovery, and why are mental health services being seen as co-opting the idea? Does recovery work for everyone? Does an individual-level understanding of recovery conceal issues of power imbalance, cultural practices and social inequality?

Theme 3: Recovery and well-being

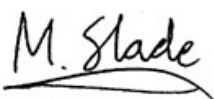
Does the term 'recovery' accurately describe what matters to people experiencing mental illness? How can people experiencing mental illness increase their well-being? What is the role of self-management? Can the experience of mental illness be an asset? How do mental health services increase, or reduce, well-being?

Theme 4: Mental health services and recovery: implementing change

What can mental health services do to support recovery? What professional values and service user expectations need to change? What is involved in organisational transformation towards a focus on recovery, well-being and social inclusion? Does the personalisation agenda make a difference?

The conference is generously supported by South London and Maudsley Charitable Funds, Guy's and St Thomas' Charity, South London and Maudsley NHS Foundation Trust, and King's Health Partners.

Warm regards



Mike Slade

Institute of Psychiatry



John Larsen

Rethink Mental Illness.

Acknowledgements

We would like to thank the following organisations for their financial support:

- South London and Maudsley NHS Foundation Trust.
- NHS National Institute for Health Research, under their Programme Grants for Applied Research scheme (RP-PG-0707-10040).
- SLAM Charitable Funds
- Rethink Mental Illness.

The conference is organised in the context of the NIHR Specialist Mental Health Biomedical Research Centre at the Institute of Psychiatry, King's College London and the South London and Maudsley NHS Foundation Trust. It has also been supported by Kings Health Partners Academic Health Science Centre. The Local Organising Committee are based in the Institute of Psychiatry Health Service and Population Research Department, which was awarded the 2009 Queen's Anniversary Prize for Further and Higher Education on behalf of King's College London. For more information about the department please visit <http://hsr.iop.kcl.ac.uk>.

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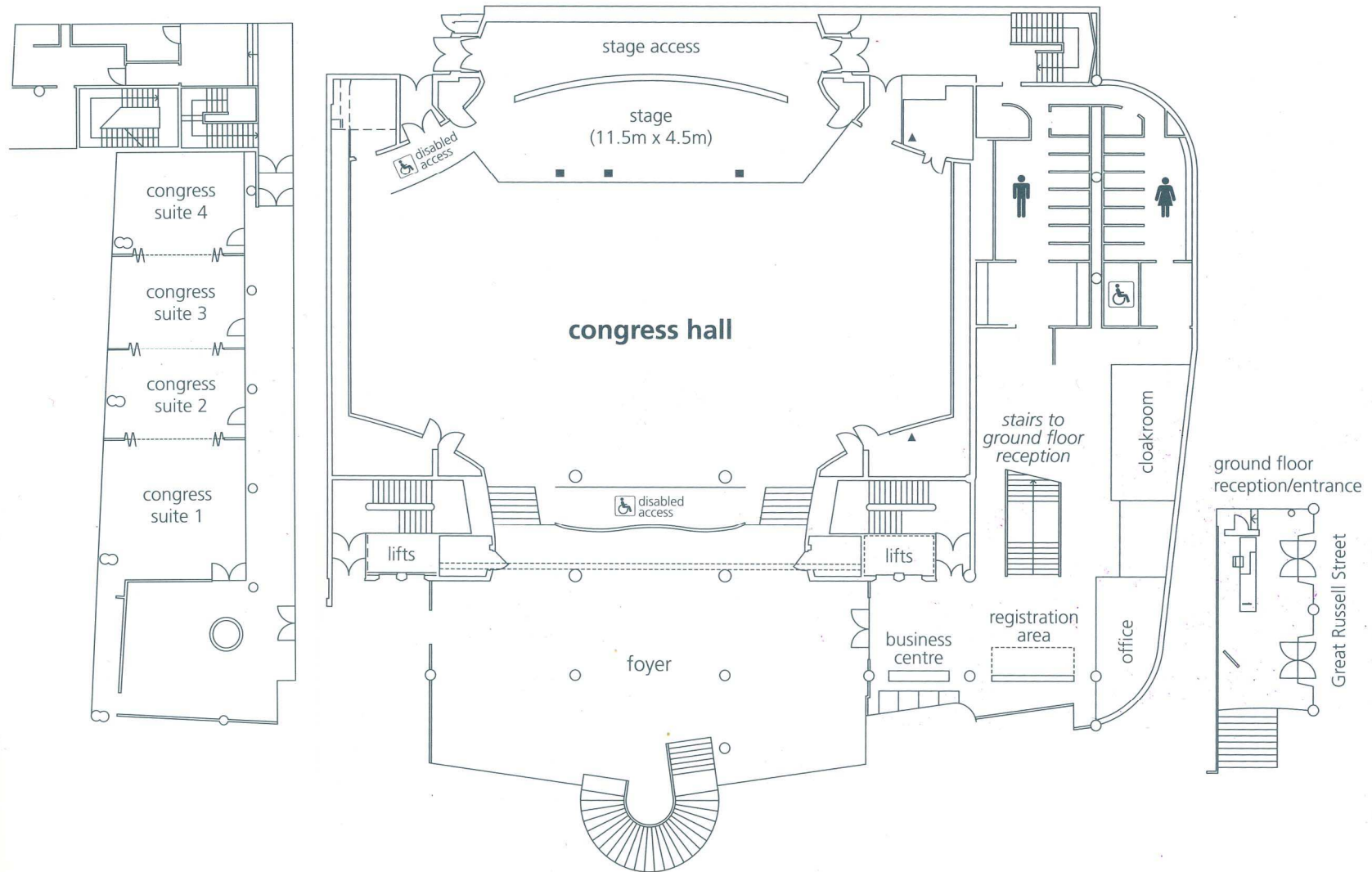
House regulations

Please wear your name badges on the premises for security reasons.

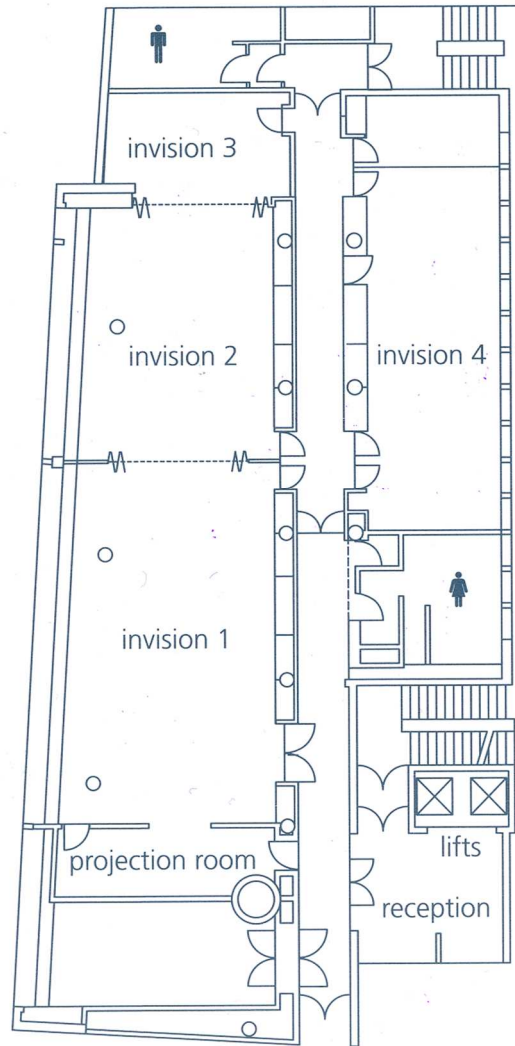
Leave all personal luggage in the cloakroom. Congress Centre and the Organising Committee cannot accept responsibility for any items lost or mislaid on the premises.

Please ensure your mobile phones are on a silent mode during all sessions.

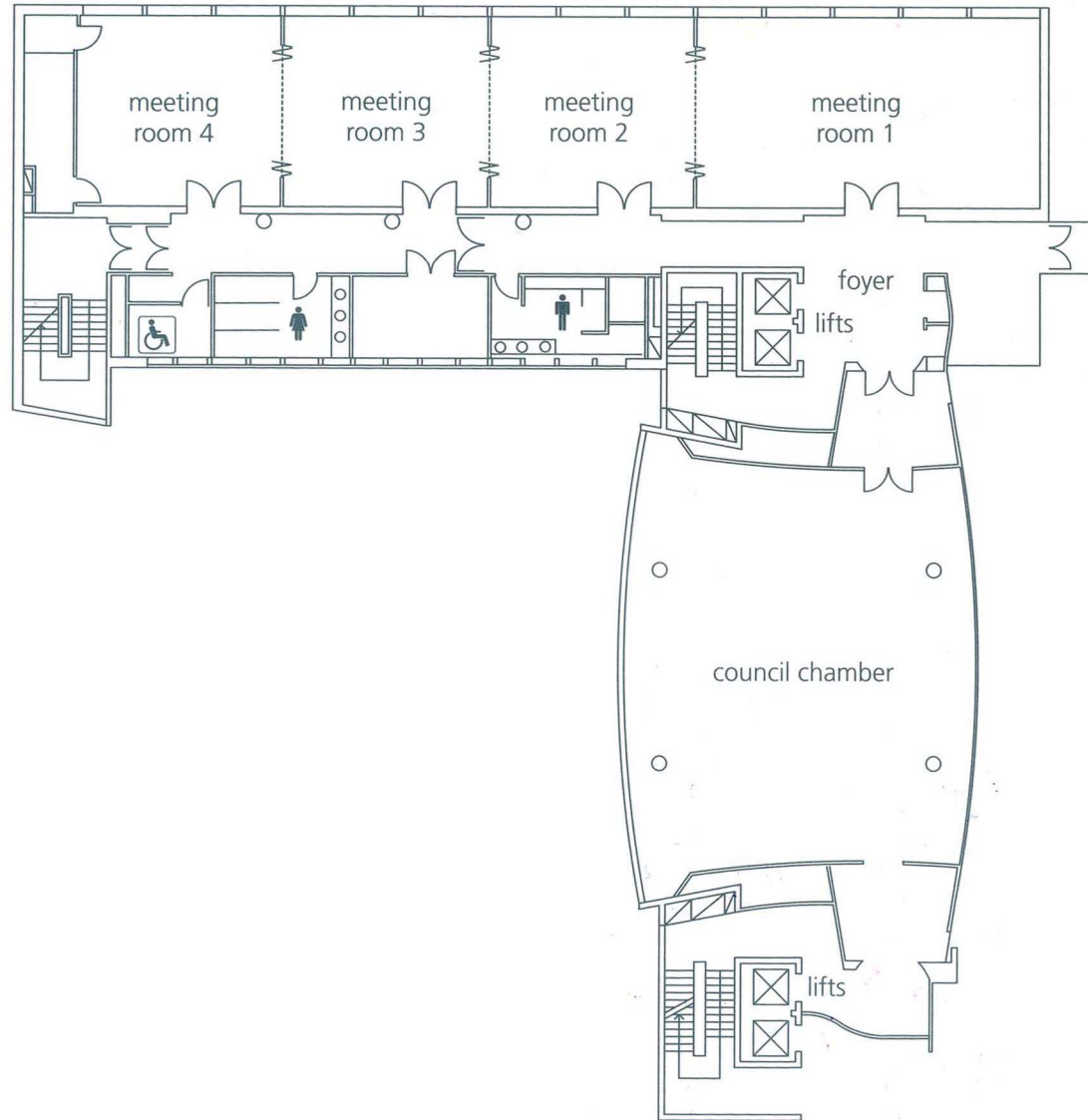
Lower Ground



2nd floor



5th Floor



Monday 5th March 2012 (am)

Refocus on Recovery 2012 Masterclasses

8.00am – 9.00am

Masterclass registration

9.00am - 12.00noon

Facilitator

Masterclass title

Venue

Glenn Roberts & Elina Baker

1. Working as a recovery-oriented professional

Invision Suite 1 (2nd floor)

Geoff Shepherd & Rachel Perkins

2. Organisational transformation towards recovery

Invision Suite 4 (2nd floor)

Tony Coggins

3. Improving well-being

Congress Suites 1 & 2 (Lower ground)

Julie Repper

4. Developing recovery values in the workforce

Council Chamber (5th floor)

Mary O'Hagan

5. Using lived experience as a trainer

Invision Suite 2 (2nd floor)

Augusto D. Mello & Pia Hansen

6. Peer Support: Transforming Lives, Transforming Services

Meeting Room 4 (5th floor)

Sarah Blakemore & Victoria Bleazard

7. Fostering social activism

Meeting room 2 (5th floor)

Monday 5th March 2012 (pm)

10.00am-1.00pm	Conference registration			
1.00pm-1.30pm	Opening remarks: Paul Jenkins (Chief Executive, Rethink Mental Illness.) Tom Craig (Director of R&D, South London and Maudsley NHS Foundation)			CONGRESS HALL Chair: Mike Slade
1.30pm-2.00pm	Plenary speaker: Vanessa Robinson			
2.00pm-3.00pm	Plenary speaker: Mary O'Hagan (Theme 2: Peer support)			
3.00pm-3.30pm	Break			
	Parallel Session 1			
3.30pm-5.00pm	<p>Session 1.1 Social rights and activism</p> <p>Invision Suite 4 (2nd Flr) Chair: Caroline Hough</p> <p>Marina Morrow – Dialoguing about Equity & Recovery: Moving beyond the individual journey.</p> <p>Helen Paris Hamer – Insiders and Outsiders: Mental Health, Citizenship and Social Justice</p> <p>Julie Rahbaek Moller – Entangled development – an anthropological analysis of residents and staff in social psychiatric residential homes in Denmark</p> <p>Wendy Bryant – Ways of Seeing: a community project based in a museum to promote inclusion</p>	<p>Session 1.2 Peer support: lived experience and role models</p> <p>Invision Suites 1 & 2 (2nd Flr) Chair: tbc</p> <p>Jorge Assis - Differences of application of paradigm of recovery in Brazil</p> <p>Ruth Chandler - Conceptual and practical challenges and opportunities in developing recovery orientated research roles with experts by lived experience</p> <p>Hanneke van Gestel - Effects and feasibility of a peer-run course on the recovery of people with major psychiatric problems: a randomized controlled trial and feasibility study</p> <p>Bridget Hamilton – Does my work badge say “peer worker”? Expectations of personal disclosure by peer workers in mental health teams.</p>	<p>Session 1.3 Mental Health Services and recovery: Implementing change</p> <p>Congress Hall Chair: Julie Williams</p> <p>Geoff Dickens - Mental Health Recovery Star: Validating User Recovery.</p> <p>Mark Ragins – Creating recovery based practice and systems based on the Milestones of Recovery Scale</p> <p>Bridey Monger – Recovery outcome measurement in a Scottish mental health charity</p> <p>Bent Schultz - Measuring recovery orientation – a presentation of a new screening and development tool</p>	<p>Session 1.4 Mental health services and recovery: implementing change</p> <p>Congress Suite 1-3 Chair: Elly Clarke</p> <p>Jayne Lewis – An evaluation of the recovery orientation of the Inner Urban East Adult Mental Health Initiatives – a partnership between Mind Australia and St Vincent’s Mental Health Service</p> <p>Mary Birken - Improving the ability to carry out daily living activities</p> <p>Shula Ramon - Implementing shared decision making in psychiatric medication management: key findings from the firstphase of a pilot project</p> <p>Brian Kjærulff - Recovery implementation in the City of Aarhus: 2011-2013 Strategy</p>
5.00pm – 5.30pm	Plenary speaker: Mike Slade (Recovery Research: ideology meets science)		Chair: Angela Sweeney	CONGRESS HALL
5.30pm – 7.00pm	Drinks reception at the Marble Hall, Congress Centre			

Tuesday 6th March 2012 (am)

9.00am – 9.30am	Plenary speaker: Paulette Ranaraja			CONGRESS HALL Chair: John Larsen
9.30am – 10.30am	Plenary speaker: Nic Marks (Theme 3: Recovery and wellbeing)			
10.30am – 11.00am	Break			
11.00 – 12.30pm	Parallel Session 2			
	<p>Session 2.1 Social rights and activism</p> <p>Invision Suite 4 (2nd Flr) Chair: Shula Ramon</p> <p>Lupin Battersby – Increasing equity in mental health and recovery through ‘Multistrand Mainstreaming’</p> <p>Helen Hutchings – Multi-Disciplinary Preceptorship in Mental Health: A Recovery Focussed Workforce</p> <p>Wendy Bryant – Researching Psychosis Together: changing lives through collaborative research</p> <p>David Rosenberg – Transcending the care paradigm – Developing participation-related services in the community</p>	<p>Session 2.2 Peer support: lived experience and role models</p> <p>Invision Suites 1 & 2 (2nd Flr) Chair: tbc</p> <p>Jennifer Newbould – An evaluation of the peer workers employment programme at Cambridge and Peterborough Foundation Trust.</p> <p>Alan Simpson – Peer support for people discharged from hospital: Results of a pilot randomised controlled trial in England</p> <p>Jacquie Kidd – Peer support in primary health care for people with experience of serious mental illness</p> <p>Marie Koenig-Flahaut – A Peer support experience in a French community service</p>	<p>Session 2.3 Mental Health Services and recovery: Implementing change</p> <p>Congress Suites 1-3 Chair: Lindsay Oades</p> <p>Alessandro Svetini – Recovery conferences and daily practice: mind the gap! An Italian experience.</p> <p>Anna Love – Turning the tide: consumer and organisational experiences of refocusing on recovery</p> <p>Anne Petersen - What Service Providers Say and Do – insight into Challenges of Implementing Recovery</p> <p>Ken Murphy - What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices?</p>	<p>Session 2.4 Mental health services and recovery: implementing change</p> <p>Congress Hall Chair: Mona Eklund</p> <p>Julie Williams – The development of a new service user rated measure of staff support for recovery (INSPIRE)</p> <p>Clair Le Boutillier – Translating Recovery to practice</p> <p>Victoria Bird – A framework of recovery support for black individuals.</p> <p>John Larsen – Using lived experience to guide research: the perspectives of REFOCUS LEAP members and collaborators.</p>
12.30pm-1.30pm	Lunch			CONGRESS CENTRE FOYER
12.30pm-1.30pm	Conference reflection session			CONGRESS SUITE
12.30pm-1.30pm	Poster viewing			CONGRESS HALL

Tuesday 6th March 2012 (pm)

1.30pm – 2.00pm	Well-being event			CONGRESS HALL Chair: Ruth Chandler
2.00pm – 2.30pm	Plenary speaker: Sidney Millin			
2.30pm – 3.30pm	Plenary speaker: Peter Beresford			
3.30pm – 4.00pm	Break			
4.00pm – 5.30pm	Parallel Session 3			
	<p>Session 3.1 Mental Health Services and recovery: Implementing change Invision Suites 1 & 2 (2nd Flr) Chair: David Blazey</p> <p>Galit Halperin – Amitim Program: An Integrative Program for the Social Rehabilitation of People with Mental Illness in the Community</p> <p>Suzie Marriott – How to introduce Recovery into everyday practice with a forensic population.</p> <p>Rosana Onocko Campos – Creating Space for the Experience of Pscyhotropic Use and Rights of Mental Health Users: a Multicentre Strategy.</p> <p>Sabine Hahn – Recovery within the psychiatric nursing process: Best practice from stakeholder's perspectives</p>	<p>Session 3.2 Recovery and wellbeing Congress Suites 1-3 Chair: tbc</p> <p>Rani Bora – 5 Ways to Well-being: How do you get the message across?</p> <p>Genevieve Wallace – To Disclose or not to Disclose? Using IPA to Explore Peer Advocates' Experiences Around Mental Health Disclosure</p> <p>Lim Kee Hean – Recovery: It's Personal</p> <p>Alice Hicks – Ups and Downs in support for Recovery: Report from service user research on experiences of people diagnosed with bipolar</p>	<p>Session 3.3 Mental Health Services and recovery: Implementing change Invision Suite 4 (2nd Flr) Chair: Mary Birken</p> <p>George Platts – Re-ablement in Mental Health Services</p> <p>Ulla-Karin Schon – Can gender sensitivity in psychiatry improve recovery?</p> <p>Henning Petersen – Recovery in patients with co-morbid substance use disorder and severe mental illness included in ACT-team.</p> <p>Tony Henderson – Consumer satisfaction survey and its impact on community psychiatric rehabilitation services.</p>	<p>Session 3.4 Mental health services and recovery: implementing change Congress Hall Chair: Alan Simpson</p> <p>Mary Leamy – The REFOCUS Intervention: developing and evaluating a pro-recovery intervention for use within community based mental health terms.</p> <p>Victoria Bird – The REFOCUS intervention manual – using a hierarchy of evidence</p> <p>Sally Gomme – Rethink personal recovery training</p> <p>Sheena Bailey – Coaching for recovery training</p>
6.00pm	Conference dinner (optional extra). Coaches will leave from the Congress Centre reception			THE OVAL, KENNINGTON

Wednesday 7th March 2012

9.00am – 9.30am	Plenary speaker: Kieran Setright			CONGRESS HALL Chair: Helen Gilbert
9.30am –10.30am	Plenary speaker: Mark Ragins (Theme 4: Mental health services and recovery: implementing change)			
10.30am –11.00am	Break			
11.00am –12.30noon	Parallel Session 4			
	<p>Session 4.1 Social rights and activism</p> <p>Invision Suite 4 (2nd Flr) Chair: Wendy Bryant</p> <p>Cecilia Villares – Educational Initiatives as empowerment strategies for users and family members of individuals with schizophrenia in Sao Paulo, Brazil</p> <p>Filipa Palha – United to help movement (UPA) in Portugal: To combat mental illness stigma and promote mental health</p> <p>Luisa Campos – UPA (United to help movement) makes a difference: A school-based intervention to promote mental health literacy and combat mental illness stigma in young people.</p>	<p>Session 4.2 Recovery and wellbeing</p> <p>Congress Suites 1-3 Chair: Clair Le Boutillier</p> <p>Emily Ainsworth – How to support self-directed recovery? Organisational lessons on the introduction of personalisation from four sites in the UK</p> <p>Shulamit Ramon – Enabling wellbeing: working with women and providers in the context of domestic violence and mental health issues</p> <p>Harriet Jordan – Development and evaluation of the five-language Clinical Decision-making Involvement and Satisfaction (CDIS) Measure.</p> <p>Bengt G Eriksson – Users’ experiences with Green Care services</p>	<p>Session 4.3 Mental Health Services and recovery: Implementing change Congress Hall Chair: Vicky Bird</p> <p>John Good – The recovery journeys of professionals</p> <p>Melissa Petrakis – Strengths model brainstorming: Getting clinicians on board with consumer and recovery orientated conversations</p> <p>Gabrielle Richards – How “recovery” documentation can contribute to care planning</p> <p>Elisabeth Argentzell – Social interaction and the importance of occupational factors: comparing day centre attendees with non-attendees in Sweden</p>	<p>Session 4.4 Mental health services and recovery: implementing change Invision Suites 1 & 2 (2nd Flr) Chair: tbc</p> <p>Nuala Conlan – Developing creative ways of involving older people and their carers in developing and changing service delivery</p> <p>Lynda McNab – Delivering a Team-based Recovery Training Intervention in Older Adult Mental Health Services</p> <p>Stephanie Daley – What are the implications of personal recovery for older people's mental health services?</p> <p>David Newton – How can we measure the recovery of Users of Older Peoples’ Mental Health Services?</p>
12.30pm – 1.30pm	Panel discussion: "I've always wanted to ask..." Chair: Glenn Roberts			CONGRESS HALL
Close	1.30pm			

Masterclasses

Monday 5th March 2012
Time: 9.00am-12.00 noon

Working as a recovery-oriented professional

Facilitators: Glenn Roberts, Elina Baker

This learning experience will be co-conducted by 2 experienced professionals and 2 people with personal experience of mental health challenges and services. Glenn Roberts, psychiatrist, and Elina Baker, psychologist have worked for many years seeking to introduce and cultivate recovery oriented practice into rehabilitation and forensic services in Devon. Caroline Nicholson and Elaine Hewis are colleagues who have extensive personal experience and are involved in user-led training and research initiatives. The workshop will consist of brief presentations drawn from personal and published experience concerning how to develop as a recovery oriented practitioner and provide a setting for lively interaction and joint learning - we will consider what helps and hinders development as practitioners and give particular emphasis on creative collaborations and co working between professionals and people in recovery.

Organisational transformation towards recovery

Facilitators: Geoff Shepherd and Rachel Perkins

This masterclass will give an update on the ImROC project which aims to help mental health services and their local partners to become more supportive of the Recovery journeys of those using them and their families. The project began in April 2011 when sites were invited to apply to join the programme. More than 30 sites responded which covered more than half the NHS trusts in England. They were assessed using a combination of written applications, site visits, and interviews. Those accepted (n=29) were assigned to one of three categories: (a) Demonstration sites (n=6); (b) Pilot sites (n=6); and (c) Network sites (n=17). Each site is now expected to use the 'Key Organisational Challenge' framework previously developed by the project team to assess their current state of development regarding recovery-oriented practice and plan for improvement (see Shepherd, Boardman & Burns, 2010, *Implementing Recovery – A methodology for organisational change*, Sainsbury Centre for Mental Health, London). Each will also receive an individually tailored programme of assistance according to their needs. The masterclass will describe the content of these programmes and progress so far. It will be illustrated by a presentation from one of the pilot sites.

Improving well-being

Facilitator: Tony Coggins

What would services look like if they focused on mental well-being as much as mental illness?

The mental health promotion service in SLAM has spent the last 6 years asking this question. This masterclass will cover:

- An introduction to the research and evidence around mental well-being.
- How we have been translating the evidence in practice for diverse communities in London.
- Include a practical session for you to try out some of the tools and approaches SLAM has been testing out including the Mental Well-being Impact Assessment, DIY Happiness www.diyhappiness.co.uk, <http://www..apho.org.uk/resource/view.aspx?RID=70495>.

Developing recovery values in the workforce

Facilitator: Julie Repper

Whilst people working in mental health services are increasingly familiar with Recovery focussed values, there is less confidence evident in the translation of these values into practice. This workshop will review the values underpinning a Recovery focussed service

- Explore the nature of practice associated with these values.
- Explore the implications of these values for relationships between people providing services and people using them.
- Explore the implementation of Recovery focussed values in staff-staff relationships throughout the organisation.
- Consider the dilemmas presented by legal and financial constraints and ways forward in spite of these potential barriers.
- Examine ways in which good practice is sustained and progressed.

The workshop will be largely interactive but examples of good practice from organisations and communities participating in the ImROC project will be used to illustrate possible developments in the implementation of Recovery focussed values.

Using lived experience as a trainer

Facilitator: Mary O'Hagan

This masterclass will explore:

- The nature of lived experience and the knowledge based that is derived from it.
- The importance of this experience and knowledge base in the development and delivery of services.
- Methods for conveying lived experience and knowledge to mental health workers and others in training.

Participants will come away with a better appreciation of user/survivor perspectives and some innovative approaches to conveying these in training and education.

Working as a peer worker

Facilitators: Augusto D. Mello & Pia Hansen

This masterclass will challenge traditional concepts of peer support, as well as exploring the dilemma between having professional boundaries and concomitantly a clear personal approach to care. It will look at the advantages and challenges of using personal experiences in order to validate and contribute to someone's mental health recovery and management, as well as necessary tools for effective peer support. Finally, it will address organisational structures needed and some of the key challenges faced when running successful peer support services whilst demonstrating potential benefits to organisations involved.

Fostering social activism

Facilitators: Sarah Blakemore & Victoria Bleazard

The work we undertake with our activists focuses on them campaigning and achieving change through direct contact with decision makers, such as politicians and commissioners. In this masterclass, we would be describing how this impacts on their recovery.

Presenter Biographies

Peter Beresford OBE is Professor of Social Policy and Director of the Centre for Citizen Participation at Brunel University. He is also a long term user of mental health services and Chair of Shaping Our Lives, the national independent service user controlled organisation and network. He has a longstanding involvement in issues of participation and empowerment as writer, researcher, educator, service user and campaigner. He is a member of the Ministerial Reference Group for Adult Social Care, a Trustee of the National Skills Academy for Social Care and a member of the Advisory Board of the National Institute for Health Research. His latest books are *Being A Mental Health Service User* (PCCS Books, 2010) and *Supporting People: Towards a person-centred approach* (Policy Press, 2011).

Tony Coggins Head of Mental Health promotion at South London and Maudsley NHS Foundation Trust. He has spent the past 6 years setting up SLaM's mental health promotion service with a remit of enabling the Trust to deliver on its strategic aim of working in partnership to promote mental well-being for all. Key to this has been developing well-being services and interventions that apply the evidence around promoting positive mental health in communities. This includes the DIY happiness project that is working with groups of women to promote mental health and well-being in 20 London communities facing the highest level of inequality (as part of the Well London programme). Tony is also one of the Authors of the Mental Well-being Impact Assessment (MWIA)- a toolkit for well-being, which enables policies programmes and services to identify and measure their potential impact on mental well-being. He is particular interested in the relationship between well-being and the "way we do things".

Pia Hansen is a consultant with excellent team and relationship management skills, specialising in participation and empowerment of vulnerable groups through peer support, training and co-production. She has an honours BA in Development Studies and an MA in International Child Welfare with further research into young people's rights and their participation in development projects. Her professional experience covers Europe and Africa. For example, she has experience facilitating the participation of young people in a community development project in South Africa, a service-user led organisation in the UK, rights to education of children with special needs in Nigeria. She has also designed and/or implemented a number of projects and training programmes for organisations such as "Look Ahead Housing and Care" and the "Citizenship Foundation" in London. She is currently managing a Peer Mentoring project for Look Ahead Housing and Care, with the intention to improve access to training and employment for people who have experienced homelessness and issues associated with it.

Elaine Hewis For a very long time I have held the belief that to enhance recovery from periods of mental distress, of whatever length or degree, a person needs to be respected, regardless of diagnosis, symptoms or presentation. I hold this belief as I feel my own journey has massively benefited from these qualities people have freely given to me. I have been heavily involved in the area of mental health research for a few years now. I have only ever worked in 'all inclusive recovery based research' before it ever became the key element it needs to be in mental health research today. I am really interested in finding ways to research and provide evidence for those very subtle but important ways which aid recovery from mental distress. My view is that if evidence is needed to show what works for us we will find ways to present it.

Nic Marks is Founder of the *centre for well-being* and has led the well-being programme at **nef** since 2001. He is a recognised expert in the field of well-being research and undertakes innovative research in the use of well-being indicators in public policy environments. Nic was the lead author of **nef's** innovative *Happy Planet Index*, a global index of human well-being and environmental impact. He was an advisor to the UK Government Office for Science's Foresight project on 'mental capital and well-being' which was published in October 2008, which included the creation of "the five ways to well-being". He devised, together with others at the centre for well-being, the model and methodology behind **nef's** report on National Accounts of Well-being, which gained extensive media coverage when launched in January 2009. Nic is regularly asked to attend speaking engagements and occupies a number of advisory positions as a result of his pioneering research. In July 2010 he gave a talk at the prestigious and influential TED global conference in Oxford, which is now available online at www.ted.com.

Augusto D. Mello has been considered one of the best service user presenters today, being ranked alongside Patricia Deegan, Rachel Perkins and Peter Bullimore. He was a teacher in computer graphics and worked in advertising for many years until he was diagnosed with Bipolar Affective Disorder thirteen years ago. The challenging years that followed brought him much insight and understanding of what it means to be a user of mental health services and, consequently, a strong commitment towards achieving full recovery. Nowadays he works as a writer and a freelance consultant and trainer in the field of promoting healthy minds, having amongst his clients Rethink Mental Illness, Westminster Mind, Slam, The Institute of Psychiatry, Kings College and Sitra. In March 2011, he also joined Look Ahead in his new role as Transformation Consultant where he is focusing on supporting the implementation of the personalisation and co-production agendas.

Sidney Millin Sidney was born in Zimbabwe where he trained and worked as a Journalist before coming to the UK in 1995. A year later he was diagnosed with Bi Polar Disorder. Sidney now works as a Service User Consultant for the East London NHS Foundation Trust and is also coordinates two East London Service User Groups. Living with a mental illness has made him passionate about championing the Service User cause and combating mental health stigma and discrimination. He regularly gives talks to various audiences as well as working as an Involvement Worker on Rethink Mental Illness's Education Not Discrimination (END) project.

Caroline Nicholson Caroline comes from an academic background in Art History, but throughout her life she has struggled with mental health issues and addiction for which she has been treated both here and in the United States. Caroline has recently become more involved in recovery matters both as a member of the Devon Recovery Research and Innovations Group chaired by Glenn Roberts, and as member of the ImROC steering group in Devon. This involvement has shed fresh light upon and taken her down unexpected new paths along her own recovery journey. She looks forward to becoming more involved in recovery based research and has recently been employed by Rethink Mental Illness as a mental health recovery worker, work to which she hopes to impart the values of a recovery oriented approach.

Mary O'Hagan was a key initiator of the mental health service user movement in New Zealand in the late 1980s, and was the first chairperson of the World Network of Users and Survivors of Psychiatry between 1991 and 1995. She was a Mental Health Commissioner in New Zealand between 2000 and 2007. Mary is now an international consultant in mental health. She has written and spoken extensively on user and survivor perspectives in many countries, and has been an international leader in the development of the recovery approach.

Rachel Perkins With a background in clinical psychology, Rachel Perkins worked in mental health services for 30 years in a range of positions including Clinical Director of Adult Mental Health Services and latterly Director of Quality Assurance and User Experience at South West London and St. George's Mental Health NHS Trust. She is now a freelance consultant and a member of the 'Implementing Recovery – Organisational Change' project team. She is also a long term user of mental health services and has had a number of national advisory roles. Currently she is a member of the UK Government Office for Disability issues advisory group - Equality 2025 - and Mind's Commission of Enquiry into Acute and Crisis Care. In 2009 Rachel was commissioned by the Secretary of State for Work and Pensions to lead an independent review into how Government might better support people with mental health problems to gain work and prosper in employment. In 2010 she was awarded an OBE for services to mental health and voted Mind Champion of the Year. Her latest book, written with Julie Repper, is Social Inclusion and Recovery: A Model for Mental Health Practice (2003, Balliere Tindall).

Mark Ragins is the Medical Director at the MHA Village Integrated Service Agency in Long Beach, California, an award winning model of recovery based mental health services. He has worked there since its beginning in 1990 as a psychiatrist for the adult service coordination teams, the Homeless Assistance Program, the Transition Age Youth Academy, and now the Welcoming Team. His practice and vision have been grounded in more than 20 years of clinical work with some of the most underserved and difficult to engage people in our community. Countless numbers of people have come to experience the work being done at the Village first hand and Mark has given hundreds of presentations and lectures to wide ranging audiences nationally and internationally. He has become one of the true pioneers and leaders of recovery based psychiatry. Many of his writings are posted at www.mhavillage.org including his short book *A Road to Recovery* which is also available at amazon.com and has been translated into Japanese and Korean. He was featured in Steve Lopez's book *The Soloist*. He has won a number of awards as well as being selected as a distinguished fellow by the American Psychiatric Association.

Paulette Ranaraja became involved with mental health when her son fell ill in 1998. After retiring from a career in education, she became a volunteer carer supporter at the West London Mental Health Trust. She takes part in Trust activities and facilitates a carers' group. Paulette delivers lectures to student nurses at various universities, covering the carers' perspective and the impact of mental illness on families. Paulette is a co-leader of the Carers Educational Training Programme (CETP) for Rethink Mental Illness and works as an Involvement Worker in the Education not Discrimination (END) programme. Paulette taught French to young adults for 38 years, and was Head of French at a leading London school. She now lives in Acton with her husband and her son and also has a daughter.

Julie Repper is Recovery Lead in Nottinghamshire Healthcare Trust, Associate Professor of Recovery and Social Inclusion at University of Nottingham, Director of two service user led voluntary sector groups and she is working on the CMH/NHS Confederation 'Implementing Recovery in Organisational Contexts' project 2 days per week. She works collaboratively with people who have lived experience to develop innovative training, research and service developments and is currently Director of the Nottingham Recovery Education Centre and leading the development of the Peer Support Workers' training and employment in her local services. She has written widely, of most relevance is the book she co-authored with Rachel Perkins: *Social Inclusion and Recovery. A Model for Mental Health Practice (2003) Edinburgh, Bailliere Tindall*.

Glenn Roberts has recently retired from clinical work after worked full time in NHS psychiatry for nearly 30 years. He is currently part time Consultant in Research and Development in the Devon Partnership Trust and Chair of the Devon Recovery Research and Innovations Group. He was senior editor of the award winning *Enabling Recovery: the principles and practice of rehabilitation psychiatry* and has won national awards with the mental health education programme for schools, *On the Edge*. He leads on Recovery for the Royal College of Psychiatrists and represented them in creation of the Joint Position Statement, *A Common Purpose*. He has a particular interest in narrative approaches to working with severe mental illness and is an Honorary Research Fellowship in the School of Performance Arts, University of Exeter.

Kieran Setright is 33 years old and was a service user in his twenties. He has also worked for the services and in various care and support worker roles. He has been well for the past six years and is currently working for Rethink Mental Illness as an Involvement Worker in the Education Not Discrimination Campaign.

Geoff Shepherd trained originally as a clinical psychologist. He has worked most of his professional career in mental health services in the NHS as a practitioner, manager and researcher, working mainly with people who have long-term and complex conditions. He has also worked outside the NHS, from 1994 -1997 he was Head of Research for the Sainsbury Centre in London and from 1997 – 2002, Chief Executive of the Health Advisory Service. In 1996, he was made visiting Professor of Mental Health Rehabilitation in the Health Service and Population Research Department at the Institute of Psychiatry. His last job in the NHS (2002 – 2006) was as '*Director of Partnerships & Service Development*' for Cambridgeshire and Peterborough Mental Health Foundation trust. He has a longstanding interest in work and employment issues for people with mental health problems and more recently has been co-leading a project based at the Sainsbury Centre exploring the problems of implementing more recovery-oriented services. He also works one day a week providing technical support and advice to mental health inreach teams in local prisons and undertakes other consultancy work.

Mike Slade is a Reader in Health Services Research at the Institute of Psychiatry, King's College London, and a Consultant Clinical Psychologist in South London. His main research interests are recovery-focused and outcome-focused mental health services, user involvement in and influence on mental health services, staff-patient agreement on need, residential alternatives to in-patient services, and contributing to the development of clinically useable outcome measures, including the Camberwell Assessment of Need and the Threshold Assessment Grid. He has written over 150 academic articles and 7 books. He co-authored *Making Recovery a Reality* (2008, free to download at www.scmh.org.uk), the most downloaded document ever published by the Sainsbury Centre for Mental Health. His most recent books are *Personal Recovery and Mental Illness* (published by Cambridge University Press, 2009) and *100 Ways to Support Recovery* (2009, free to download at rethink.org/100ways). Further information on his research programme is at researchintorecovery.com.

Social Programme

5.30pm-7.00pm on Monday 5th March 2012

Drinks Reception at Marble Hall in Congress Centre



Tuesday 6th March 2012

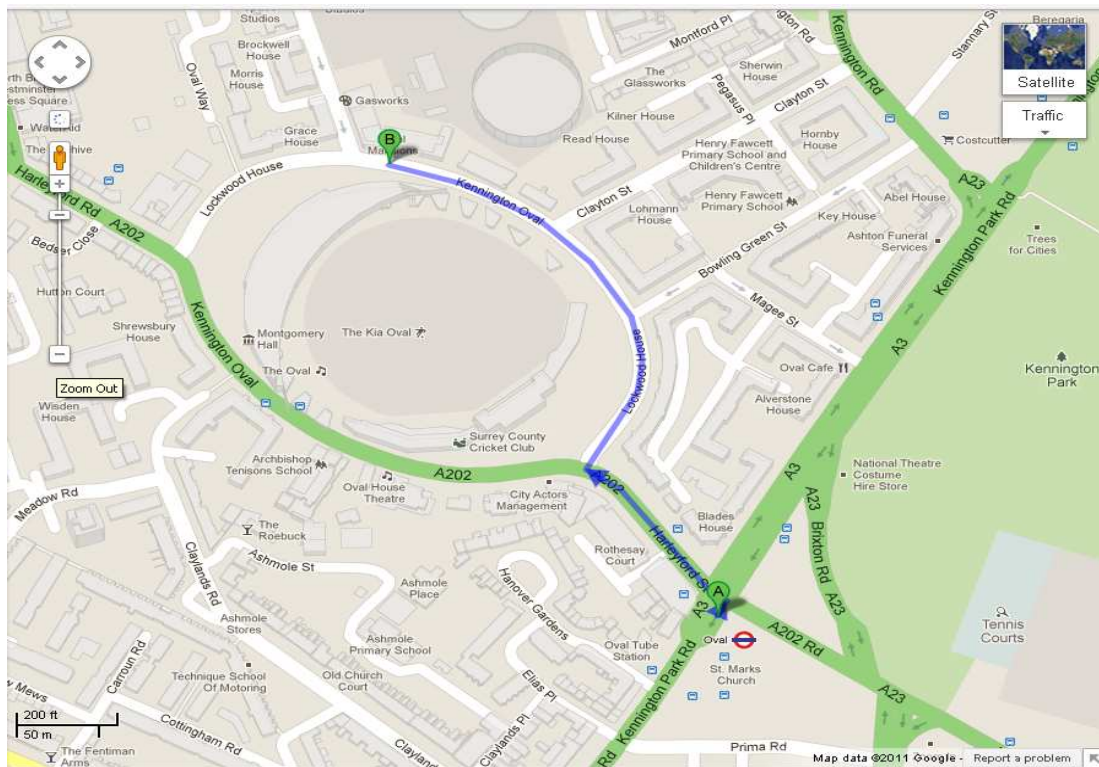
Conference dinner, The Oval cricket ground



Coaches depart 6pm outside Congress Centre. Dinner starts at 7pm.

(Optional extra, tickets (£59) available to buy at the registration desk)

For people travelling independently to the conference dinner, go to Tottenham Court Road Station and take northern line (direction Morden) and get off at Oval. Directions from Oval to venue:



ORAL PRESENTATIONS

Parallel Session 1

Session 1.1: Social rights and activism

Dialoguing about Equity & Recovery: Moving beyond the individual journey

Marina Morrow

Despite a well established research literature that illustrates the ways in which mental distress is intimately linked to social inequities (e.g., poverty, racism, sexism), the social and structural determinants of mental health continue to be marginalized in discussions and applications of recovery. This marginalization can be attributed to the continued dominance of biomedicine in mental health but is also tied politically to the discursive practices of neoliberalism that serve to individualize mental health problems. This paper explores the ways in which the current political context constrains dialogues on 'recovery', reinforcing resource allocations that favour psychiatric over social care in mental health.

Methods

The paper draws on the results of a World Café roundtable held in Vancouver, Canada in conjunction with a review of the recovery literature. The World Café participants included PWLE, practitioners, academics and policy actors who came together to identify current definitions, models, and conceptualisations of recovery and to explore recovery in its intersections with social inequities.

Results

The results suggest that current understandings of recovery fail in their analysis of the role of social and structural inequities in mental health. Most of the attention has been given to recovery as an individual journey tied to medical, family and community supports with less attention being given to the structural changes needed to ensure adequate income, housing and social environments that are free of discrimination. Despite this there is evidence that new conceptualisations of recovery are emerging which begin to address limitations.

Discussion

Recovery as a concept and a paradigm is poised to either disrupt biomedical dominance in favour of social and structural understandings of mental distress, or to continue to play into individualistic discourses, which work against social change. Much depends on the ways in which the current political climate can foster broad reaching recovery dialogues.

Insiders and Outsiders: Mental Health, Citizenship and Social Justice

Helen Paris Hamer

The philosophy of recovery in New Zealand is based on a social justice platform and the right to full citizenship for people with serious mental health problems. However the concept of citizenship for service users has not been fully explored or empirically investigated. Findings from the author's qualitative study will explicate the participants understanding of citizenship and whether the current framework of recovery-focused care in New Zealand helps or hinders the person's journey towards full participation in society.

Using a political, economic and sociological lens, the reframing of service user as a political actor and activist citizen will be presented. The current focus on social inclusion, the 'responsibilised' citizen and recovery as a form of self-surveillance will also be addressed. The impact of these findings for the clinician as the professional-citizen and the relevance for future clinical and political practice will be discussed.

Entangled development - an anthropological analysis of residents and staff in social psychiatric residential homes in Denmark

Julie Rahbaek Moller

Introduction

Social psychiatric services in Copenhagen, Denmark have recently implemented two central strategies concurrently; a strategy to implement a 'recovery-oriented' approach, and a flow strategy to ensure a 'flow' of service users out of social psychiatric institutions to more independent ways of living. This study examines why and how the intended implementations of these two central strategies do not comply with the interpretations and negotiations taking place in practice amongst social workers and residents at social psychiatric residential homes.

Methods

Ethnographic methods were used. During a seven months ethnographic fieldwork amongst staff and residents in two social psychiatric institutions and at the Municipality of Copenhagen amongst administrative workers, data was collected by participant observation, interviews, focus groups and photography.

Results

Results reveal how the implementation of recovery-oriented strategies take different forms than intended, how they counteract each other and how they are understood and used in practise. A majority of residents do not experience a need or wish for a life without daily staff in more independent housing. This does not comply with neither of two central strategies and complicates the relationship between social workers and residents, creating dilemmas between the duty to care for residents on the one hand, and the resident's autonomy and citizenship on the other.

Discussion

Concepts such as 'flow' and 'recovery' are increasingly used in political strategies for multiple reasons, e.g. ideological, financial and organizational. This study reveals how the strategies of 'flow' and 'recovery' are experienced by the residents as both as both helpful and unhelpful. Transforming the individual from dependency on the welfare state to independent citizens raises the question on how the 'citizen' is constructed as a political product and shows that people with mental illness have their own understandings of how to create spaces of action in their lives.

Ways of Seeing: a community project based in a museum to promote inclusion

Wendy Bryant, Lesley Wilson, Jackie Lawson

Museums and galleries aim to engage with local communities to promote social inclusion and participation in the arts. The Ways of Seeing project, funded by the Heritage Lottery, was based at the Lightbox, a gallery and museum in Woking, Surrey, UK. Starting in 2008, it aimed to involve local mental health service users, preparing for an exhibition of artwork in 2011. The project gave participants access: to other galleries and studios; to learning opportunities for specific art techniques and art history; to experience of curating an exhibition; to each other; and to the Lightbox itself. Modern artwork from an extensive and valuable local source, the Ingram Collection, was used as a basis for learning and to inspire artistic responses from the participants. They selected their responses to exhibit alongside the original pieces from the collection. The Ways of Seeing exhibition was visited by 6530 members of the public, with 148 people leaving comments cards. Their comments are the focus of this presentation, drawing parallels with the experiences of service users which were captured in individual interviews. Mental health issues were evident at the exhibition and the context enabled visitors to engage with different ways of seeing both the artworks and mental health as an issue. It is suggested that the different elements of the exhibition, as a project outcome, had a profoundly positive impact on both visitors and those involved. Developing similar projects could offer valuable opportunities to foster inclusive communities and empower people with direct experience of mental health services.

Session 1.2 Peer support: lived experiences and role models

Differences of application of paradigm of recovery in Brazil

Jorge Assis, Cecilia Cruz Villares and Rodrigo Affonseca Bressan

Introduction

Brazil is a country of continental dimensions, marked by great social inequalities, the major part of population live in conditions of poverty or below the poverty line, with a high degree of functional illiteracy. Community mental health services are insufficient. Given these conditions, the implementation of the paradigm of recovery demands a differentiated approach that takes in consideration the socio-economic status of users and their relatives.

Methods

The first author of this abstract has initiated his process of recovery after 18 years with schizophrenia. With the support of other authors of this presentation, in the last 8 years has overcome his difficulties and became vice-president of the Brazilian Schizophrenia Association, Ombudsman of PROESQ, international lecturer, and teaches to students and residents of the medical program.

He heads a project of a structured countrywide network of NGOs, in phase of implementation. The project is based in the concept of participative research, using a portal in WEB 2.0 and a virtual

social network, with the aim of disseminating the paradigm of recovery, advocacy and the invigoration of leaderships in the country. It's also part of this project to lecture and teach courses in diverse regions of the country.

Results

Internet based technologies allow collecting quantitative and qualitative data about the proposal of dissemination of the paradigm of recovery, considering the socioeconomic conditions of each region of the country, and using interactive processes. The lectures and courses allow the invigoration of personal social networks and the invigoration of leaderships that can be empowered by use of the internet.

Discussion

This work proposes to present the partial results of quantitative and qualitative data about the proposals of the process of recovery, in a underdeveloped country, its possibilities, difficulties and singularities.

Conceptual and practical challenges and opportunities in developing recovery orientated research roles which experts by lived experience

Ruth Chandler

Doing recovery-orientated research within infrastructures that are not designed to be recovery-orientated presents difficult conceptual and practical challenges for the most well intentioned researcher. This paper charts some of these tensions and ways to negotiate them through critical reflection on the development of two lived experience research roles at SPFT. The first development considered is the formation of LEAF to advise and collaborate with researchers across the research cycle and across the full spectrum of research. Taking INVOLVE guidance as a point of departure, this group has also adapted the critical friendship model that originated in the LEAP for REFOCUS to ask difficult questions in a constructive manner.

This model has been successful in working with clinicians to develop bespoke involvement strategies across a range of methodologies. LEAF has also put power differentials in decision making firmly on the governance table. The second role, still in its infancy, is the development of Peer Researchers combining some of the skills of Peer Support Workers with Research Assistants. Scientific reasons for employing Peera are that we may be better placed to reach disaffected groups and elicit a more honest view. These roles also offer a much needed opportunity for career progression. It is too early to assess this initiative. Nevertheless, training of the Peers has raised methodological questions about stepping in and back from experience during data collection and qualitative analysis of findings.

Conceptually, our conclusion is that a post-positivist methodology is required to account for the contested values of recovery-orientated research. Practically cultural buy in is still needed for such initiatives to flourish in research environments. It is hoped that the addition of social impact to the Research Evaluation Framework may provide an incentive to make recovery-orientated research practices more attractive to researchers, funders and publishers and contribute towards cultural change.

Effects and feasibility of a peer-run course on the recovery of people with major psychiatric problems: a randomized controlled trial and feasibility study

Hanneke van Gestel, Evelien Brouwers, Marcel van Assen, Chijs van Nieuwenhuizen

Introduction

Research on the effectiveness of peer-run services on the recovery of people with major psychiatric problems has been limited and poorly controlled. Effects of the peer-run course 'Recovery is up to you' on recovery were evaluated and its feasibility was assessed.

Methods

Recruitment of people with major psychiatric problems took place in the Netherlands between 2006 and 2008. The effects were evaluated in a RCT design. A total of 333 people were randomized to the experimental condition (N=168) or control condition (N=165). Assessments took place at baseline, after 3 months (i.e. at the end of the course) and after 6 months. Data were analyzed using multilevel analysis.

For the feasibility study interviews were held with course instructors and participants after each course. 38 courses were evaluated. Clients were specially trained and involved as research assistants in the study.

Results

After three months, participants had significantly higher scores on key elements of recovery: empowerment, hope and self-efficacy beliefs. The effects of the intervention persisted three months after finishing the course. Similar results were found for those in the control condition when they participated in the course six months later.

The feasibility study showed that participants and course instructors had very positive experiences with the course. Course instructors adhered closely to the course protocol and there were no structural problems with the standardized manual. Participants mentioned three important factors for their recovery: the presence of role models, the group process and the course material.

Discussion

The positive effects found in the present study are likely to be explained by: the presence of role models, sharing of personal experiences and also the elements of psycho-education and illness management in the course. The findings imply that the peer-run course contributes to the improvement of important domains of recovery.

Does my work badge say “peer worker”? Expectations of personal disclosure by peers workers in mental health teams

Bridget Hamilton, Emma Sierakowski

Peer worker positions have been established in many Australian community support services, as part of a Commonwealth funded program called Personal Helpers and Mentors (PHaMs). This paper will report on complex issues of peer worker disclosure of their experiences of mental health issues and of service provision. The discussion comes from our analysis of focus group interviews in 2009 with peer workers and team leaders from several PHaMs funded teams.

It is evident that expectations can differ between individual peer workers and among mental health practitioners about the issue of peer worker disclosure, across diverse organisations, teams and geographic areas. In the absence of clear direction, informed by peer workforce, pressure can be placed on peer workers to either disclose aspects of their experiences on demand, or to suppress or withhold information about their own experiences.

Attention must be given to this issue, so that peer workers retain control over what they helpfully disclose, when and where and to whom. Issues for organisations to consider include: assessing team readiness and recognition of the expertise of peer worker colleagues, the need for all staff orientation, and planning for distinctive models of ongoing support for peer workers.

Session 1.3 Mental health services and recovery: implementing change

Mental Health Recovery Star: Validating User Recovery

Geoff Dickens, Judy Weleminsky, Yetunde Onifade and Philip Sugarman

Introduction

Mental Health Recovery Star is a multifaceted outcomes measure and keyworking tool that has been widely adopted by service providers in the UK. This study aimed to explore the factorial validity, internal consistency, and responsiveness of the measure.

Methods

Recovery Star readings were conducted twice with N=203 working age adults with moderate to severe mental health problems attending a range of mental health services and a third time with N=113 of these individuals.

Results

Mental Health Recovery Star had high internal consistency and appeared to measure an underlying recovery-oriented construct. Results supported a valid two-factor structure comprising six psychological items and four social items which explained over 58% of variance in Recovery Star ratings. There was good item validity and item responsiveness and there appeared to be no obvious item redundancy. Data for a small number of variables were not normally distributed and the implications of this for future development are discussed.

Discussion

Recovery Star has been received enthusiastically by both mental health service providers and service users. The current study provides further evidence for its adoption in recovery-focused mental health

services and indicates that items relating to addictive behaviour, responsibilities, and work could be further developed in future.

Creating recovery based practice and systems based on the Milestones of Recovery Scale

Mark Ragins

Introduction

Recovery focuses not just on treating illnesses, but also on helping people live well with their illnesses. People at different levels of recovery will benefit from differentiated recovery techniques. For example, for people who are unengaged, we should focus on engagement, for people who are engaged but poorly self coordinating we should focus on building skills and supports and self responsibility and for people who are self responsible we should focus on building self reliance and community integration. The Milestones of Recovery Scale (MORS) gives us a short tool to help make those service differentiation decisions based on their stage of recovery rather than their diagnosis or illness acuity.

Method

I will describe the logic behind the scale and how to rate people. We will then move on to discussing how knowing someone's MORS stage can help focus our practice and programs.

Results

By condensing the MORS into 3 stages – unengaged, engaged but poorly self coordinating, and self responsible - we can differentiate services by stage – e.g. employment and medication services. I will describe care taking vs. growth oriented approaches, goals, tasks and values for each of these stages. By adapting services to level of recovery, we can avoid common challenges of insight and readiness. The MORS can even form the basis for recovery-based system design.

Discussion

Recovery can progress from being an add-on to traditional services to being the entire system in a coherent and comprehensive way that includes people at all stages of recovery.

Recovery outcome measurement in a Scottish mental health charity

Bridey Monger, Dr Robin Ion, Nigel Henderson and Dr Scott Hardie

Introduction

The concept of recovery has become increasingly embedded in UK mental health care policy. A commitment to recovery based care is now explicit in the training programmes of most mental health professionals and in the mission statements of many mental health services across the country. While a great deal of work has been done in terms of defining the concept and exploring how recovery focussed care might be delivered in practice, there is relatively little work that examines recovery as an outcome variable. This is consistent with many other areas of mental health work where outcome measurement is often misunderstood or overlooked.

Methods

The individual Recovery Outcomes Counter (i-ROC) was designed in discussion with service users, mental health workers and following review of the literature. The reliability and validity of the tool are currently being assessed and in this paper we describe the process being undertaken to establish the value and utility of the measure. These include evaluation of the tool's usability, analysis of its psychometric properties and benchmarking against other similar measures.

Results

Here we present details of our initial findings and explain how these have, and will be used to inform the later stages of the project. We also describe some of the practical issues we have faced over the course of work with a view to informing the management of other similar projects.

Discussion

We present a case for the robust measurement of recovery as an outcome variable for service users and providers. We also describe the process used to design and establish the reliability and validity of a tool to measure recovery in mental health. We discuss the progress made on this project to date.

Measuring recovery orientation - a presentation of a new screening and developmental tool

Bent Schultz

Introduction

Over the past year the Department of Social Services in the City of Aarhus has collaborated with VIA University College to develop a screening tool to use for assessing an organizations degree of recovery orientation. Many workplaces have requested a tool to continuously show whether they are

on the right track implementing a recovery orientation. The tool has been tested in three organizations and will be implemented in the entire Service Field of Social Psychiatry and At-Risk Adults in the City of Aarhus during the year 2012. In our presentation we will present the tool and experiences from the first completed pilot tests.

Methodology

A project group of national authorities within the field initiated their collaboration with a literature retrieval to uncover existing tools. Based on these and knowledge, an innovation theory-workshop was conducted to pinpoint the important points of impact which became the focal point for screenings in a Danish context. Subsequently, these points of impact have been challenged and qualified by an external expert panel and a manual for screeners has been developed. Presently, an educational programme for screeners (professionals as well as users) is under preparation. The screening processes have been organized to include a significant level of user involvement.

Results

Following the pilot tests, the responses and feedback from the participants have been very positive. The tool has shown its strength as a development tool that provides an insight into the current degree of recovery orientation. It also inspires workplaces in their continued effort to implement recovery orientation.

Discussion

We invite participants to join us in a discussion on how screenings can be utilized actively when it comes to ensuring a stable anchorage of recovery orientation in a large organization.

Session 1.4 Mental health services and recovery: implementing change

An evaluation of the recovery orientation of the Inner Urban East Adult Mental Health Initiatives - a partnership between Mind Australia and St Vincent's Mental Health Service

Jayne Lewis, Lisa Brophy, Mellisa Petrakis, Kieran Halloran, Nadine Cocks, Liam Buckley, Matthew Scott, Michael Stylianou

This paper reports on an evaluation of an innovative new model of service delivery – the Adult Mental Health Initiatives (the initiatives), a collaboration between Mind Australia and St Vincent's Mental Health (SVMH) in Melbourne, supporting people with severe and enduring symptoms of mental illness and complex needs. Both services aim to embed a recovery model to achieve consumer focused, integrated, holistic and targeted service delivery.

To improve and develop the service being provided, feedback was sought from consumers via two consumer-rated recovery-orientation-of-the-service measures: the Recovery Enhancing Environment measure (REE) and the Recovery Self Assessment (RSA) (consumer version). The experience of the consumers in completing the measures was also investigated by inviting them to rate the relevance of the tools and their preference to determine the more appropriate recovery measure for future program evaluation.

Methods

The research team reflected the structure of both services, involving managers, researchers, workers and consumer consultants. The consumer consultants played a central role by engaging consumers who wished to participate to explain the process and facilitate completion of the measures.

Results

Findings from four aspects of this project will be presented:

- 1) Key learning from the research process
- 2) Collective consumer feedback via collated responses to REE and RSA items
- 3) Implications for enhancing the recovery orientation of the service being provided under the initiatives.
- 4) Plans for the ongoing use of the REE and RSA in both services

Discussion

- The participation of the consumer consultants as researchers greatly enhanced this research activity.
- The collaboration of the key stakeholders to engage recovery-orientation- of-the-service measurement was valuable.
- Each tool generated useful consumer feedback to guide service improvement.

Improving the ability to carry out daily living activities

Mary Birken, Mike Slade, Claire Henderson

Introduction

Current literature describes personal recovery as a process of establishing hope, self identity, and meaning in life. The approaches described in the literature to promote personal recovery however, have focused predominately on changing ones' cognitive processes. Despite much of daily life consisting of carrying out activities that are personally meaningful, the development of skills, and ability to carry out these activities have been less well described as approaches to promote personal recovery. Deterioration in mental state and an admission to hospital may also disrupt daily routine and the ability to carry out meaningful occupations. This presentation describes the development of an intervention to improve occupational performance for people with a diagnosed psychotic following discharge from hospital. Several sub studies were carried out to inform the intervention. The sub studies were, a systematic review of interventions, literature review of theory and studies of occupational performance, and focus groups with service users and clinicians, were carried out to provide best evidence on which to base the intervention. The intervention developed, GLOW, Graduating Living Skills Outside the Ward, aims to improve a persons ability to carry out self care and leisure occupations at a time of transition, following discharge from an acute mental health ward. The intervention is currently being piloted in a mental health NHS trust. It is hoped that this study will add to the body of knowledge regarding interventions to prevent long term disability and support personal recovery for people with a diagnosed psychotic disorder.

Implementing shared decision making in psychiatric medication management: key findings from the firstphase of a pilot project

Shula Ramon, Amy Li, Sheena Mooney, Nicola Morant

The ShIMME project (shared involvement in medication management education) is an NIHR RfPB funded project, aimed to deliver and evaluate a piloted intervention to encourage shared decision making (SDM) in psychiatric medication management. It is a partnerships between a trust and a university University. SDM is essential to enhancing control over one's lives, a key objective of the new meaning of recovery. It is also a key to changing power differentials and relationships between professionals and service users, a necessity for recovery oriented mental health services

While the desirability of achieving SDM between service users and prescribers relating to psychiatric medication is consensual, little has been developed regarding processes of SDM in this area, in comparison to implementation developments related to long term physical illnesses. Thus understanding the barriers and opportunities entailed in implementing SDM is essential.

As part of the first phase of our project in which we are designing an intervention that is both evidence-based and responsive to stakeholders' needs and concerns, consultation groups were conducted with service users, psychiatrists,, CPNs and care co-ordinators . These groups have different yet important roles to play in processes of psychiatric medication management.

Applying small group interactive methods, with a psychiatrist and a service user as co-leads, the consultations focused on what each stakeholder group considered to be the key issues in SDM in psychiatric medication, the barriers and opportunities to facilitate it. Participants were also asked about their preferences for the content and format of the training programmes to be offered to these groups later in the project. All transcripts were thematically analysed by three researchers.

Key findings from the consultation groups will be outlined in the presentation, highlighting reservations about SDM in this field, hopes and fears related to its implementation, and suggestions for successful training programmes.

Recovery implementation in the City of Aarhus: 2011-2013 strategy

Brian Kjaerulff

Introduction

Over the past year the Department of Social Services in the City of Aarhus has collaborated with VIA University College to develop a screening tool to use for assessing an organizations degree of recovery orientation. Many workplaces have requested a tool to continuously show whether they are on the right track implementing a recovery orientation. The tool has been tested in three organizations and will be implemented in the entire Service Field of Social Psychiatry and At-Risk Adults in the City of Aarhus during the year 2012. In our presentation we will present the tool and experiences from the first completed pilot tests.

Methodology

A project group of national authorities within the field initiated their collaboration with a literature retrieval to uncover existing tools. Based on these and knowledge, an innovation theory-workshop was conducted to pinpoint the important points of impact which became the focal point for screenings in a Danish context. Subsequently, these points of impact have been challenged and qualified by an external expert panel and a manual for screeners has been developed. Presently, an educational programme for screeners (professionals as well as users) is under preparation. The screening processes have been organized to include a significant level of user involvement.

Results

Following the pilot tests, the responses and feedback from the participants have been very positive. The tool has shown its strength as a development tool that provides an insight into the current degree of recovery orientation. It also inspires workplaces in their continued effort to implement recovery orientation.

Discussion

We invite participants to join us in a discussion on how screenings can be utilized actively when it comes to ensuring a stable anchorage of recovery orientation in a large organization.

Parallel Session 2

Session 2.1 Social rights and activism

Increasing equity in mental health and recovery through 'Multistrand Mainstreaming'

Lupin Battersby, Susan Hardie, Marina Marrow, Judith Cook

Introduction

The experience of recovery varies depending on an individual's social location, however, policy tools are inadequate for addressing equity issues. In partnership with the Mental Health Commission of Canada (MHCC), the researchers identified a shared interest in exploring social and structural inequities and the use of an intersectionality/multistrand approach to improve policy development. Intersectional analyses take into account that social identities such as race, class, gender, ability and age interact to form unique meanings and complex experiences within and between groups in society. It offers an alternative to the 'additive approach' to policy making.

The research team and the MHCC identified self-directed care (SDC) as the policy area to explore because it is an emerging strategy for supporting recovery. SDC provides people with control over money to purchase mental health/health services, as well as goods for recovery.

The goals for the project were: 1) to explore the SDC policy possibility for Canada; and 2) evaluate "Multistrand Mainstreaming" (Parke & Young, 2008) for evaluating policy that is equitable and responsive. The focus of this paper is on the utility of Multistrand Mainstreaming for fostering policy changes that are equitable and support recovery in mental health.

Methods

In keeping with the Multistrand approach we convened an Evidence Panel and completed the first two (of four) stages: mapping the evidence and visioning. Included in our analysis are meeting minutes and interviews with Evidence Panel members and the research team.

Results

The Multistrand method surfaced tensions regarding SDC and whether it is a suitable recovery based policy option, particularly in relation to fostering equity.

Discussion

Multistrand Mainstreaming is a promising approach to policy analysis, implementation and evaluation; fostering collaborative partnerships; enhancing awareness of the complexities of mental health policy and health inequities; and, encouraging the reduction of social inequities in mental health.

Multi-Disciplinary Preceptorship in Mental Health: A Recovery Focused

Helen Hutchings

The Multi-Disciplinary Preceptorship in Mental Health programme facilitates the transition of newly qualified mental health professionals to the status of independent accountable practitioners. This enables them to address issues relating to the translation of theory to recovery focussed practice. The preceptorship is a 6 day programme facilitated by a range of people with personal or professional mental health expertise where preceptees are provided with the opportunity to explore, reflect upon, build upon, challenge and discuss their experiences in relation to their new roles and responsibilities. Unlike traditional preceptorship, this is a values based programme with lived experience at its heart. Preceptees are provided an environment in which they too are able to open up and consider their own mental wellbeing.

Some of the themes covered during the days are: recovery at the heart, personal stories, language, recovery based prescribing, safety, choice, responsibility and recovery, detention and compulsion, safeguarding and cultural capability. Evaluation of the programme found that preceptees hugely valued the opportunity to meet and talk openly with people with lived experience and multi-disciplinary staff. The recovery approach was no longer regarded by the participants as an "add on" but just "my way of working – not something extra".

Approachable and friendly facilitators were essential in creating an atmosphere that encouraged discussion and where people felt able to challenge and question. Peer support is an essential component of the programme, and group feedback indicated that the preceptees felt less isolated after being given the opportunity to share similar challenges. 4 month post course follow up indicated that participants are working with a strong recovery approach, some of which have begun to proactively take projects forward within their teams.

I will review our experience to date, lessons learned and consider how Multi-Disciplinary Preceptorship can support the cultural change towards recovery orientated services.

Researching Psychosis Together: changing lives through collaborative research

Wendy Bryant, Charlie Andrews and John Clark

Involving people with direct experience of mental health services is valuable for research, especially when the findings can be used to improve services and influence policy. Doing research together has other benefits for the individual researchers involved, whatever their role. The Researching Psychosis Together group, based at Brunel University, has been working since 2007, bringing together people who have used local mental health services, academic and clinical occupational therapists, and post-graduate students.

Motivated to influence and improve the experience of using mental health services for people living with psychosis, the group has now experienced a complete cycle of research, from initial ideas to publication. The various activities involved have required us to recognise diverse interests and skills at different stages. This presentation will examine the experiences of group members, considering recovery and citizenship. Details will be shared of how the group came together and how the research design was agreed. University Knowledge Transfer funds were used to support learning about research and post-graduate students were co-opted to lead data collection phases. Other small sources of funding were obtained to support the group's work. The findings have been shared, involving speaking to and writing for different audiences. All members, regardless of background, have successfully developed and sustained their involvement in research and wider community activities.

This success has been achieved by recognising, and welcoming, different priorities and capacities within the group. The challenges to doing this will be identified, to provoke discussion about authentic user involvement. This involvement is believed to be essential to successfully promote recovery for everyone. It is based on the idea that everyone involved is a citizen, with a valid and valuable role to play, and is a challenging but vital basis for research.

Transcending the care paradigm- Developing participation-related services in the community

David Rosenberg, Urban Markstrom and Rafael Lindqvist

Introduction

Despite the ideological direction described in Swedish legislation, which emphasizes rehabilitation and the right to participation in community life "as all others", the development of recovery oriented services has been sluggish. The authors question whether the comprehensive welfare system, which includes many potential supports to the recovery process, might begin to redefine the service structures and professional cultures which frame the experience of individuals seeking support.

Methods

A recently completed national research project included a series of surveys of community-based need related to serious psychiatric impairment, interviews with municipal service providers and documentation studies. The surveys included non-traditional, generic services and supports, in order to collect data from a broader population than those exclusively in contact with formal mental health services. The overall aim of the study was to investigate the meeting between individuals experiencing serious psychiatric impairments and welfare system structures, including but not limited to, community-based mental health services.

Results

Up to 50% of those identified in the surveys avoided contact with formal mental health services. They instead, in many cases, utilized generic community services in order to satisfy their self-defined need for support to participate more actively in community life. Jobs, studies, social contacts and other natural community involvements were not seen as being supported by the mental health system, which tended to categorize need based on a medically-based care paradigm. A lack of rehabilitation and recovery-oriented services was also experienced by the majority of active clients.

Discussion

Knowledge of recovery may be utilized to analyze and explain the manner in which individuals negotiate their contact with traditional mental health services. The research studies presented here describe areas of need related to participation in community life and possibilities for recovery that service systems working from a care paradigm are not currently prepared to address.

Session 2.2 Peer support: lived experience and role models

An evaluation of the peer workers employment programme at Cambridge and Peterborough Foundation Trust

Jennifer Newbould, Sharon Gilfoyle, Tom Ling, Claire and Alex Pollittdouble check names

Cambridge and Peterborough NHS Foundation Trust are seeking to adopt a more recovery focused approach to supporting service users. This Trust wide initiative involves an organisational shift to a recovery focused approach and includes the introduction of the role of peer workers, individuals who have lived experience of a mental health challenge and work with service users. To date there is little known about the most effective way to employ peer workers within an organisation.

This presentation will outline the origins and aims of the peer employment programme and how the programme has been implemented. We report on the findings of a qualitative evaluation of the peer employment programme, conducted by RAND Europe. Our findings draw on interviews and focus groups with service users, peer workers, managers and other staff employed by the Trust.

Issues explored include the awareness of the programme amongst employees, practical aspects of running the programme and the organisational shift to the recovery focused approach. The perceptions of service users, peer workers and other staff of the impacts of the peer employment programme will be reported.

We discuss the challenges to implementing such a change throughout the Trust including use of recovery focused language, resistance to change and the current financial climate. Benefits of the programme are also noted to the organisation, peer workers and service users.

We conclude by examining some of the lessons learnt from the experience of Cambridge and Peterborough NHS Foundation Trust and issues which may be of interest to other Trusts considering the adoption of a recovery focused approach to the provision of mental health services.

Peer support for people discharged and hospital: Results of a pilot randomised controlled trial in England

Alan Simpson

Introduction

Being discharged from a mental health hospital can be a difficult time: service users often miss the 24-hour presence of nursing staff and the companionship of fellow service users. Relapse and re-admission is commonplace. We developed a team of peer supporters to test whether the additional provision of peer support to a group of service users facing discharge from hospital would help their recovery, compared with people receiving usual aftercare only.

This presentation outlines independent research funded by the National Institute for Health Research (NIHR) under its Research for Patient Benefit (RfPB) Programme (Ref No. PB-PG-0408-16151). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health.

Methods

A pilot randomised controlled trial was conducted, using mixed methods. Quantitative measures included questionnaires, activity diaries and service use data. Qualitative methods included interviews and focus groups. Data was collected at recruitment; one-month and three-months following discharge. Experiences of peer support were obtained in interviews with peers and focus groups with peer supporters and professional staff. Framework analysis was employed.

Results

A total of 47 service users were recruited into the study; 23 randomly allocated to peer support, 24 to care as usual. Follow-up data collection continues at time of writing. In this session we will include the first presentation of the key results from this pilot RCT and draw on the qualitative data analysis to explore the lived experience of peer support from the viewpoint of peers and peer supporters.

Discussion

The results and findings will be discussed in relation to the international literature on peer support with recommendations made for developing peer support services within and alongside mental health services in England. Some of the challenges of conducting the trial will also be explored.

Peer Support in primary health care for people with experience of serious mental illness

Jacque Kidd

Introduction

The last 10 years have seen the growing involvement of peer support services at all levels of specialist mental health service provision. Despite strategic direction from the New Zealand government that emphasises primary mental health care, people with serious mental illness are often not discharged from specialist care in a timely manner because of the perceived lack of the necessary resources in primary care. Furthermore, efforts in the primary health sector have focused to date on such 'mild to moderate illnesses' as depression and anxiety, where short term counselling and antidepressants are viewed as optimal responses.

This presentation gives interim findings from a study into the practicability, barriers, strengths and risks of adopting peer support services in primary health settings for people with experience of serious mental illness. A potential model of care will be described for discussion.

Methods

Semi-structured interviews have been undertaken with a range of key stakeholders from the mental health and primary health sector, including peers, advocates, clinicians and academics. Attention has also been given to the Māori worldview.

Results

Interim findings from the thematic analysis will be presented, along with the proposed model of primary mental health care by peer supporters.

Discussion

This research is focused on developing a model that is underpinned by the primary health tenets of self-management, early access to care, and the promotion of healthy behaviours. These can be conceptually linked to key mental health recovery focuses of voice, agency and choice that underpin peer support work. The concept of risk associated with peer support work, both from a clinical perspective and in terms of risk to the peers of 'clinical contamination' and maintaining their own mental health will also be explored.

A Peer support experience in a French community service

Marie Koenig-Flahaut, Marie-Carmen Castillo, Jean-Herve Bouleau and Alain Bouleau

Introduction

In the mental health area, the practice of peer-support was initially developed in North America, with the increasing of the recovery movement. In France, despite benefits proved by this approach, peer-support is still facing both theoretical and institutional reluctances. We propose then to report the primary phase of a peer-support project in a French community service centered on the rehabilitation of schizophrenic patients. This primary phase compares the peer-support project's representations in a sample of caregivers (6 nurses, 2 psychologists, 2 psychiatrists), patients (n=5) and by the lived experience person.

Method

- (1) We assessed the caregivers' representations with a semi-directive questionnaire.
- (2) We recruited a voluntary patient to make an intervention centered on his recovery journey in a psychoeducational group. We conducted a semi-structured interview with him to assess the way he lived this experience.
- (3) We assessed the benefits, waiting and potential fears of patients using an anonymous semi-directive questionnaire.

Results

- Caregivers (n=10) give causes for apprehensions with the risk of place confusion between caregivers and lived-experience person. Also, some caregivers remain skeptics about the possibility of recovery in schizophrenia.
- All patients (n=5) describe the benefits of the psychoeducation session in terms of hopefulness for a positive evolution and a better grasping of personal strategies to cope with the symptoms.
- The lived-experience person has lived his testimony like "a positive and naturalistic experience" which enables the attribution of sense of his life events.

Discussion

This first experience of peer-support in our French community service shows globally positive and encouraging impacts. Therefore, our results show that the main reluctances are amazingly reported by caregivers.

Conclusion

We need to focus on the staff supervision formation by promoting the concept of recovery and by sharing experiences with other European staffs.

Session 2.3 Mental Health Services and recovery: Implementing change

Recovery conferences and daily practice: mind the gap! An Italian experience

Alessandro Svettoni, Robert Paul Liberman, Martin Werth

Introduction

The International Conference on Recovery (ICR) was held in Bolzano (Italy) on May 5th-6th, 2011. More than 20 speakers from across Europe and U.S.A. approached the subject from the different stakeholders' perspectives.

About 380 participants (professionals, consumers, family members and administrators) came mainly from Italy, but also from other European countries.

Methods

After two months, participants were contacted via e-mail and asked to complete a short feedback form on how they had experienced the conference in terms of its effects on their professional/personal reality of every day, being them positive changes or obstacles encountered in putting into practice the contents of ICR.

Results

The still ongoing collecting phase has already given several feedbacks from the different stakeholders' categories. Some elements are frequently reported and can be found cross-sectionally among different stakeholders, like renewed hope and a confirmation of the personal/professional approach to severe mental illness.

The most commonly found element is the resistance, especially of professionals, towards the perspectives of recovering.

Suggestions for further aspects of recovery to be dealt with in a future conference have also been collected, many of them indicating the need to eradicate stigma and prejudices of poor outcomes for individuals with psychiatric disorders.

Discussion

A preliminary elaboration of the collected material shows already the very strong presence of prejudices especially in the professional workforce. This appears to be one of the biggest obstacles to be removed in order to have recovery-oriented services.

As already shown by the scientific research on the subject, single events are not sufficient: to change prejudices direct exposure of individuals to subjects recovered from severe mental illness is needed. Public conferences are excellent opportunities to share experiences, to generate realistic enthusiasms and to create networks. These represent the fundamentals to continue the process of fighting prejudices on a daily small-size basis.

Turning the tide: consumer and organisational experiences of refocusing on recovery

Anna Love, Matthew Scott, Brad Wynee

St Vincent's Mental Health has systematically implemented a recovery oriented model of care into a clinical mental health setting in Victoria, Australia. This has involved an all-of-leadership commitment, to the model and to recovery orientation in a public mental healthcare organisation. In our experience, fostering a recovery oriented culture is an ongoing process, in the current context of risk-averse healthcare practice and with the need to shift the orientation of clinicians from being the experts, to partnering with consumer expertise.

We show evidence of making incremental change, with illustrations of practice change and associated data from six years experience. Elements include: consulting consumers throughout the implementation; starting strong by staging implementation in the most intensive teams that provide community based care; changing routine paperwork to reflect strengths not deficits; recruiting staff for congruence with values; enlisting champions in role modelling and training roles; adapting the community-based recovery focussed model for our acute care teams; and undertaking a strong program of evaluation, to establish baseline data, and routinely review fidelity and outcomes. The practical examples and outcomes will highlight changes across the diverse inpatient, acute care and case management teams that comprise the service.

What Service providers Say and Do - insight into challenges of Implementing Recovery

Anne Petersen

Introduction

Recovery has become part of most Danish strategies on provision of services to people with a mental illness, as well as a word used by most service providers. At the same time, implementation of recovery is criticized for being mostly lip service with practices proceeding as before. This study examines how recovery is understood by service providers, and how practices reflect recovery-orientation as well as a number of other organizational and informal strategies.

Methods

Ethnographic methods were used. By mixing participant observation over a period of six months and interviews with 25 service providers at a social psychiatric housing, a closed hospital ward and a psychiatric emergency ward, I gained deep insight about the practices and everyday life at the units, and how the service providers perceive and enact strategies.

Results

Understandings of recovery among service providers vary greatly: from understanding recovery as an individual process to an objective scoring method. Daily practices (e.g. meals) are often completely decoupled from values otherwise expressed as important in the relationship with service-users. Instead informal strategies such as 'nursing the collegial relationship' influence practice.

Discussion

Different understandings of recovery lead to different perceptions of which practices are meaningful in order to support/treat the service users. These perceptions may affect whether service is something you give to the service user or something you collaborate with the service user about. At the same time, other co-existing strategies affect the relationship between service user and provider, and the strategies may have goals and practices that counteract a recovery-oriented approach. To transform organizations towards a focus on recovery, it is therefore essential to focus on how recovery is understood and what practices these understandings imply. Furthermore, it is essential to focus on integrating recovery-oriented values into existing practices that (without further reflection) are reproduced daily.

What kinds of discourses are service users and staff drawing on during the adoption of recovery-oriented practices?

Ken Murphy, Sue Holttum, Caroline Cupitt

Mental health policy initiatives have called for a central emphasis on recovery-oriented practice for mental health services in the UK (New Horizons, 2009). However, the change from the traditional disease model, and the values and practices of services informed by it, has been problematic. There are many reasons for this including the difficulty of embracing change from a professional led, illness and symptom centred care to a client centred, strengths-based empowerment model (Slade, 2007). Some work has been done around how services can become more recovery-oriented, but implementation of these recommendations has been patchy. The current project aims to begin a process of inquiry that will explore the discourses of service users and staff when their service adopts recovery-oriented practices which have the aim of enhancing their access to opportunities and offering them the supports they need to pursue meaningful lives, even within the confines of mental health problems. The project will be guided by social positioning theory (Harre & van Langenhove, 1999) and will use a Foucauldian discourse analysis of service user and staff focus groups. Results will inform services around the implementation of recovery-oriented practices, and may suggest a new way of theorising recovery oriented service development as a social process of re-positioning service users and staff and re-discoursing of the service context.

Session 2.4 Mental health services and recovery: implementing change

The development of a new service user rated measure of a staff support for recovery (INSPIRE)

Julie Williams, Mary Leamy, Mike Slade, Victoria Bird, Clair Le Bouillier

Introduction

Recovery has become a key aim for mental health services. How this philosophy translates into practice has been the focus of research to assist staff in how best to do this. Two key issues are how to assess staff support for recovery, and how users of service experience this support. Measures of the recovery orientation of services exist but problems have been identified with all of these measures,

including that none have been developed in the UK. A new measure, 'INSPIRE', has been developed for use in English Mental Health Services within the REFOCUS research programme. The development and validation process are described in this presentation. Further uses of INSPIRE will also be discussed.

Methods

Measure development guidelines were followed in the development of INSPIRE. There were three phases of development – i) initial development of the measure including the initial item pool and scoring format, ii) three consultation exercises with experts, and iii) pilot with 20 current users of mental health services.

A psychometric validation process is ongoing to address key properties of internal consistency, test-retest reliability, construct validity, and sensitivity to change. This is being done with 80 service users in South London and involves participants completing INSPIRE and related measures three times over three months.

Results

The current version of INSPIRE has two sub-scales – support and relationships. Both sub-scales are rated using a Likert scale.

Discussion

INSPIRE is a new measure that attempts to assess the service user experience of staff support for recovery. The issues raised in the development process including how to staff support for recovery will be discussed. The results from the validation process will be described and discussed. The use of INSPIRE to evaluate a Randomised Controlled Trial of recovery interventions, and in other projects, will also be discussed.

Translating Recovery to Practice

Clair Le Boutillier, Mike Slade, Mary Leamy, Vanessa Lawrence, Victoria Bird, Julie Williams

Introduction

A key challenge for mental health services is the lack of clarity around what constitutes recovery-orientated practice (Le Boutillier et al, accepted). A translational gap remains between promoting recovery and its adoption in routine practice (Hardiman & Hodges, 2008). The study aims to a) explore how recovery is translated into practice by staff and b) investigate factors associated with successful implementation of recovery in NHS community-based mental health practice.

Methods

The study develops a grounded theory of staff experiences of implementing recovery-orientated practice (Strauss & Corbin, 1990). The decision to use grounded theory was made because staff perspectives are relatively unexplored. Following ethical approval, purposive sampling was used to recruit focus groups (n=10) with community mental health team staff and team leaders (n=65) across five NHS mental health Trusts (South London and Maudsley NHS Foundation Trust, 2gether NHS Foundation Trust, Leicestershire Partnership Trust, Devon Partnership Trust, and Tees, Esk and Wear Valleys Foundation NHS Trust). Preliminary focus group analysis informed subsequent individual interview schedules, and theoretical sampling was used to identify staff and team leader participants (n=15).

Results

Preliminary findings identify context-specific differences in the translated meaning of recovery to practice; factors at the individual, team, organisational and societal level impact on the success of implementation and understanding. The characteristics of the system and characteristics of staff that support successful implementation of recovery are identified and the early findings will be presented.

Discussion

Recovery is a nebulous concept that has many meanings and is difficult to apply. Some aspects of recovery-orientated practice are evident, but only when a shared translation of the concept exists across all levels of the health system will it be capable of being fully implemented.

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A framework of recovery support for black individuals

Victoria Bird, Mike Slade, Tom Craig, Clair Le Boutillier, Julie Williams

Background

A recent systematic review and narrative synthesis highlighted that out of 97 papers assessing models or frameworks of recovery, only 6 specifically focused on non-majority populations. Furthermore, only one paper focused on the meaning and perceptions of recovery for black individuals within the UK. Understanding the perspectives of people from minority ethnic communities is fundamental in enabling services to match the needs of the diverse communities they serve, and better support the recovery of all individuals. We aim to address this research gap, by developing a framework of recovery support for black individuals.

Method

The framework of recovery support was developed from a qualitative study. This included five focus groups and 15 semi-structured interviews with individuals from black communities who use adult community mental health services. The framework was used to design a module of the REFOCUS intervention manual, which is currently being tested within a multi-site randomised controlled trial (RCT).

Results

“Identity” emerged as the core category within the preliminary framework. In particular, “threats to identity”, “the loss of the person” and “regaining a positive sense of identity” were all central to the framework of recovery support for black individuals. Within these categories themes such as the “Meaning of the illness experience”, “Meaning of recovery”, “Barriers and facilitators within society” “Barriers and facilitators within the system”, were all evident. As were themes such as “the importance of spirituality and religion”, “culturally specific facilitating factors”, “understanding different explanatory models of illness” and “individualistic vs. collectivist values”.

Conclusions

The importance of a positive sense of identity was vital in supporting the recovery of individuals from black communities. The implications of the preliminary framework of recovery support will be discussed alongside the practice recommendations for mental health services.

Using lived experience to guide research: the perspectives of REFOCUS LEAP members and collaborators

John Larsen, Maurice Arbouthnott, Tina Braitwaite, Ruth Chandler, Alison Faulkner, Jo Fox, Ruth Hennem, Elaine Moore, Premila Trivedi

Introduction

Service user and carer involvement (SUCI) is crucial for development of a modern NHS, but is too often simply consultative with little or no authority. In mental health, where there is a re-focusing towards embedding recovery, authoritative SUCI is essential in research, service development, organisational change and clinical practice. The REFOCUS study introduced SUCI by setting up a Lived Experience Advisory Panel (LEAP) to guide the research, facilitated by a Chair based in a Third sector organisation.

Methods

Experiences and views were collected via an email questionnaire sent to current and past LEAP members and others who had had (direct or indirect) experience of the LEAP. Feedback was sought on three core questions: (1) what was your experience of the LEAP, (2) what influence do you think it had, (3) what lessons were learnt. The findings were analysed by LEAP members.

Results

Responses showed diversity not only between stakeholder groups, but also within groups and sometimes within individuals at different times during the project. More positively, involvement with the LEAP was of benefit to many individuals (on personal and/or professional levels) and also to REFOCUS as a whole, bringing about shifts and changes that would not have occurred if the LEAP had not existed. Less positively, some individuals reported significant challenges during their involvement with LEAP.

Discussion

By focusing on the process as well as the content of LEAP, it was possible to see how, sometimes (with third sector space for engagement) challenges could be faced and worked through (albeit

painfully), and led to important new learning, positive change and an increase in LEAP's authority. Reflecting on the process as well as the content of SUCI is crucial, so that important lessons are not lost and SUCI enabled to move from being purely consultative to truly authoritative.

Parallel Session 3

Session 3.1 Mental health services and recovery: implementing change

Amitim Program: An Integrative Program for Social Rehabilitation of people with Mental Illness in the Community

Galit Halperin, Talya Boz-Mizrahi

We would like to present a unique program of social rehabilitation for adults with mental illness (MI) in the community: The 'Amitim'(that means peer) program. The program founded in 2001 by the Israeli Ministry of Health and the Israel Association of Community Centers (IACC), Offers the opportunity to be integrated in leisure activities with the general population which consumes the community center services.

The community centers operate in most communities in Israel, where they provide a wide range of low-priced social, educational and cultural activities; classes in sports, music, art, dance, trips and other activities. The 'Amitim' Program provides a coordinator whose main function is to facilitate the integration of people with MI into the various activities offered. The coordinator is a member of the community center staff. He functions as a mediator between the community and the people with MI and causes both parties to be more accessible to one another. Making the community more accessible to the people with MI is achieved by individual and group meetings with the coordinator in which a social rehabilitation program is build and issues that arose during the activities and the social skills needed are discussed. Making the people with MI more accessible to the community is achieved by public awareness activities in various groups that participate in the community center activities (teenagers, senior citizens, volunteers, etc.).

The support system offered by 'Amitim' program can play a central role in the individual's recovery process .The sense of ability and the positive experience of realization pleasure and success in leisure time, can help to build a positive capable self and to improve the quality of life by lessening the feelings of loneliness, isolation, boredom, and meaninglessness and by strengthening one's self image and self confidence and one's sense of belonging to the community.

How to introduce Recovery into everyday practice with a forensic population

Suzie Marriott, Hilary Marton, Lucy Swatling and Alice Hucker

Introduction

Inmind Healthcare Group is a group of independent mental health hospitals providing low secure and open rehabilitative services for men and women over eighteen years of age, nationwide. All patients using Inmind services have complex mental health needs, many of whom have come through forensic mental health care pathways, though not all.

Inmind Hospitals already work in a recovery-focused way, and local initiatives are in progress aimed at:

- Changing the day-to-day ethos and culture into being truly recovery-focussed.
- Improving outcomes for service-users.
- Reducing the length of stay in Inpatient services.

This work is part of a wider care pathways agenda in progress across the Group.

Methods

This presentation/paper will consist of several short papers, given by Lead Inmind clinicians and the topics are:

- The design and build to completion of a life-sized Recovery tree, with pictures to illustrate progress along the way (Alice Hucker, Doulton Lodge).
- Developing Recovery-focused care pathways through our services, from Low Secure to the community (Suzie Marriott).
- Developing Recovery Training with service-users and setting up a Recovery Group co-designed and facilitated with a service-user (Hilary Marton and Service-user, Waterloo Manor).
- Designing and delivering joint service-user and staff training on the concepts of recovery and what it means to individuals (Suzie Marriott and Alice Hucker).

The development and pilot of a Recovery Star CPA outcomes-based report for CPA meetings, being implemented in October 2011. Pilot sites are the Men's Low Secure Service and Community Rehabilitation and Recovery Service (Suzie Marriott, Jenny Judge and Lucy Swatling).

Results

Within each short presentation, the lead presenter will give a brief summary of the method and initial results of the initiatives. Aggregated recovery-focused outcomes will be presented and the results discussed to see if it has had a positive impact on day-to-day service-user experiences.

Discussion

Our recovery work is very much action research in progress and it is hoped that the individual early results presentations will generate interest and the sharing of ideas. We wish to involve conference participants in the discussion around our approach to changing practice so recovery and hope is instilled into everyday encounters between service-users and staff within Inmind Services.

Creating Space for the Experience of Psychotropic Use and Rights of the Mental Health Users: a Multicentre Strategy

Rosana Onocko Campos, Sabrina Stefanello, Deivisson Vianna Dantas dos Santos, Catarina Dahl

Introduction

In Brazil, changes from hospital-centered to a community-centered treatment in Mental Health had broadened the clinic requiring a psychosocial view. However, raising psychotropic prescriptions and low empowerment of mental health users are observed in community mental health services in Brazil and in other countries offering universal health care. The aim of the study was to adapt and test a strategy, developed in Quebec/Canada, to address such problems.

Methods

In three large cities with different public mental health network scenarios, this multicentre study translated and adapted the "Critical handbook of psychiatric drugs" (CHPD), developed in Canada. During two years, Intervention Groups (IGs) developed the Brazilian version based upon shared experiences on medication treatments from subjects brought up by the translated guide. Pre- and post- IGs focus groups were held and several qualitative validation methods applied. This was a participative research in which the users of the public system had voice.

Results

One main result was the lack of space to discuss and reflect about drug treatment and the low qualification of professionals working with mental health to support their patients regarding such relevant theme. To adapt the handbook for the Brazilian reality required major changes comparing to its initial version and brought to light a powerful tool to produce novel experiences for users of mental health services and for mental health staffs, including the increase of awareness for such theme, but also dealing with ethical, political e rights dimensions.

Discussion

The CHPD was not a technical instrument, but a guide to facilitate the discussion of the experience of medication and rights of mental health users. The adaptation of a foreign recognized material was a long process, calling the attention for the fact that mere translations may not be adequate without a qualitative approach.

Recovery within the psychiatric nursing process: Best Practice from stakeholders perspectives

Sabine Hahn, Dirk Richter, Thomas Schwarze

Introduction

Psychiatric nursing has been confronted with new and different theoretical and practical approaches for years, e.g. Recovery, Empowerment, Social Inclusion, Motivational Interviewing, and Coaching. Continental Europe is still far from successful implementation of these approaches in daily practice. One reason for the lack of practical implementation is due to the fact that publications are often in English and require cultural adaptation before implementation in the specific healthcare system is possible. Additionally, the approaches should fit the professional role and competences of nursing staff.

Methods

To facilitate the implementation of the different approaches, we conducted a literature review and synthesis to identify the core elements of psychiatric nursing. Subsequently these core elements of psychiatric nursing were evaluated in three focus group discussions with users, relatives and psychiatric nursing staff. Finally, the results were integrated in a Delphi study and evaluated by users, relatives and nursing staff in the context of Switzerland.

Results

90 persons participated in the two rounds of a Delphi survey (24 users, 21 carers, 35 nursing staff). Respondents agreed that mental healthcare is not limited to reduction of disease symptoms, but includes reduction of symptoms as an important goal to reach. Good mental healthcare is characterized by a patient- and process-oriented approach. A respectful and appreciating interaction with users was rated as the most important characteristic of a psychiatric nurse. Health means an improvement or relief of disease, allowing to lead an independent and meaningful life. The extent of inclusion and information of the relatives was rated as a more controversial topic.

Discussion

Users, relatives and nursing staff in Switzerland have a clear picture concerning the meaning of best practice in psychiatric care. The differences of the approaches in other countries are small but important. Cultural adaptation is important for acceptance of new approaches in practice.

Session 3.2 Recovery and wellbeing

5 Ways to Well-being: How do you get the message across?

Rani Bora, Emma Hoerning

Background

There is widespread interest in and concern for mental and emotional wellbeing in both the population and the healthcare workforce. The Government Office of Science commissioned the New Economics Foundation to develop a set of health education messages parallel to the existing '5 a day' for physical wellbeing. This led to the '5 Ways to Wellbeing', a series of evidence-based strategies supporting positive action towards personal well-being. This guidance was published in Foresight report on Mental Capital and Wellbeing in 2008 but there has been very patchy awareness, take up or engagement until very recently.

Our project

We investigated how to 'get the message across', starting with healthcare practitioners, through developing and piloting focused educational resources. An hour long interactive educational session explaining and exploring the '5 Ways' was delivered to 3 mental health and 4 primary care teams, supported by uniquely designed promotional materials. The impact and learning was evaluated and a project report delivered to our health care Trust.

Project outcome

Our project has been cited as an example of good practice in the recent NHS Confederation's national review of the Five Ways to Wellbeing, New Applications, New Ways of Thinking (2011, p27). We have produced a number of educational support resources including a comprehensive report, self-help booklet, promotional film and powerpoint presentation all available through both the Devon Partnership Trust and Recovery Devon Websites. From the latter site alone, each material has been downloaded over 200 times over a few months giving an indication of the interest shown.

Presentation

we could offer either an experiential workshop to delegates, facilitating personal reflection on 'the 5 Ways to wellbeing', or a talk – both reviewing our experience of teaching and learning and illustrated by our educational support materials.

To Disclose or not to Disclose? Using IPA to Explore Peer Advocates' Experiences Around Mental Health Disclosure

Genevieve Wallace

Introduction

Despite the increase in the use of peer workers in mental health services in the UK there is very little research about how it is for peer workers to negotiate decisions around disclosure. Mental illness can be considered an invisible stigma and consequently decisions around disclosing mental health difficulties can be complex and anxiety-provoking. Extant research has highlighted the benefits to service users of peer workers sharing their experience, however stigma and discrimination on the grounds of mental illness remains pervasive. This research seeks to explore how it is for peer mental health advocates to make decisions around disclosing their experiences of mental health difficulties to their clients.

Method

Data was collected from participants (n=4) using a semi-structured interview. Analysis was carried out using Interpretative Phenomenological Analysis, in order to capture the multifaceted and individual nature of participants' subjective experiences around disclosure. Analysis yielded superordinate and subordinate themes, taking great care to ensure analysis were grounded in the original data.

Results and Discussion

Emerging themes indicated self-disclosure to be seen as a way to 'prove' lack of judgement, as a 'shortcut' to trust and to install hope of recovery. Participants were motivated to disclose in order to alleviate the client's isolation and despair and to find meaning in their own suffering. However participants also described fear of being judged to be 'unprofessional', selective self-stigma, and considerations for the 'safety' of both themselves and the client. Participants reported 'permanently reflecting' on whether or not to disclose, and if so how much. Implications for the support needs of peer workers are considered.

Recovery: It's Personal

Lim Kee Hean, Frances Reynolds, Michael Iwama, Bella Vivat

This doctorate research explores the lived experiences of mental health service users as they journey through their own recovery.

The study examines:

- The personal nature of mental health recovery.
- The value of occupation in contributing to mental health recovery.
- The utility of the Kawa model in assisting participants to explore, understand and map their personal journey of recovery.

A qualitative research methodology was adopted with participants recruited via a mental health charity. The eight participants were interviewed a total of five times at three monthly intervals, throughout one year of their lives. The interviews focused on their personal narratives, perspectives and experiences of mental health recovery. With participants exploring the range of factors that both promote and hinder their recovery and the value of engaging in occupation. Participants were also introduced and guided in utilising the Kawa Model in mapping, visualising and exploring their recovery as a river journey. The interview were analysed via Interpretative Phenomenological Analysis.

Research findings indicate strong social networks, personal relationships, spiritual faith, creative expression, voluntary work and a sense of personal contribution as key in promoting personal recovery. Factors such as isolation, family pressures, boredom, loss of hope and pressure to be in paid employment as hindering recovery. Participants highlighted the value and importance of meaningful activities and occupations in promoting and supporting their mental health recovery.

Participants also indicated the simplicity and visual qualities of the Kawa Model, as beneficial in assisting them to explore, reflect upon and gain insight into their personal recovery and in exploring their diverse life experiences.

Ups and Downs in Support for Recovery: Report from service user research on experiences of people diagnosed with bipolar

Alice Hicks, Peter Mailey, Ruth Sayers, Roger Smith, Chris Griffiths, John Larsen

Introduction

Anecdotal evidence suggests that some people diagnosed with bipolar may have very different experiences of receiving support, care and treatment in the different phases of their condition. Exactly what these experiences are, how personal recovery processes are affected and the roles that supportive friends and family can play, has not yet been studied systematically and in depth.

Methods

A team of five service user researchers trained and supported by the Rethink Research Department are carrying out the research. They developed the interview guide and will undertake in-depth semi-structured interviews with 15 people diagnosed with bipolar disorder and 10 people nominated as a supporter or carer by the person with a bipolar diagnosis. Data analysis will be conducted using an innovative reflexive approach, making use of insights arising from the personal experiences of the service user researchers.

Results

At the time of writing this abstract (early September 2011) interviews have just started. Our presentation will describe the process of developing the interview guide. This led to detailed discussion of the incremental nature of people feeling 'up' or 'down', and questioned assumptions of

'wellness'. These issues will be further explored in the qualitative interviews. Our analysis will provide a picture of resources, support and care that people draw on when they are in a manic or depressive episode. We will describe barriers and enablers to more effective support, engagement and care of people with enduring but fluctuating mental health conditions.

Discussion

By gaining an understanding of how to best engage with people when they are 'up' (manic) or 'down' (depressed), health professionals, as well as supportive friends and family, will be able to provide better quality care, support and treatment. Appropriate support needs to be provided to support recovery in consideration of people's contrasting 'high' or 'low' episodes.

Session 3.3 Mental health services and recovery: Implementing Change

Re-ablement in Mental Health Services

George Platts

Re-ablement is an approach to delivering services which is intensive and time limited. It has primarily been delivered to older adults with the aim of promoting independence and reducing ongoing support needs. This paper describes work undertaken by Camden & Islington NHS Foundation Trust to evaluate whether re-ablement can be adapted to a mental health context and provide similar benefits to service users. It outlines the role and work of the Mental Health Re-ablement Service, a pilot project which ran from July 2010-June 2011, and details the evaluation process and its findings. This is the first time the re-ablement model appears to have been tested on this client group.

The evaluation aimed to measure user benefits, impact on services, and any consequential effect on service costs. The re-ablement intervention appeared to have a positive effect on user quality of life, mental health and social functioning measures and provided a 59% reduction in support need amongst service users. A forty nine percent saving was made in the cost of services as a consequence of this reduction in support. Additionally, the service received positive feedback from service users and professionals. The report concludes that the service appears to be of benefit to users and identifies ways in which outcomes could be further improved.

Can gender sensitivity in psychiatry improve recovery?

Ulla-Karin Schon

Introduction

In recent years research on recovery have resulted in new knowledge and gained relevance in the mental health field. Still recovery is discussed in terms of individual journeys to find ways to live a hopeful and satisfying life. Taking the concept of gender into consideration it is possible to begin to address additional questions about how women and men influence their recovery; how they perceive and understand the society in which they live, and how they are likely to be regarded and treated within that society.

Methods

In a study conducted in Sweden 30 first-person accounts of recovery from mental illness were examined. The study was undertaken to determine if there was gender diversity in what people described as being decisive factors for their recovery.

Results

The results illustrates a gender advantage for the men in their ability to make use of the psychiatric services offered in their coping strategies mainly focusing on remission, education and control over symptoms. The women, on the other hand, described hospitalization and psychiatric medication more in terms of coercion and helplessness. These results may raise the need for a gender perspective in psychiatry to reduce the female impediment to access to safe and effective psychiatric care. But the results also illustrate how gender norms, outside psychiatry, benefit women more than men in a recovery perspective. In spite of structural gender inequalities, female gender norms seemed to be an advantage in the recovery process. The female recovery process was focused on making sense and meaning, whereas the male recovery process was focused on reinforcement of traditional roles such as occupation and independence. The women also had a higher capacity to receive and maintain support from their social networks than did the men.

Recovery in patients with co-morbid substance use disorder and severe mental illness included in ACT-team.

Henning Petersen, Dr Anne Landheim, Torleif Ruud, Edle Ravndal

Introduction

Persons with co-morbid substance use disorder (SUD) and severe mental illness (SMI) are suffering from complex problems, and are in need of services from different agents and levels of the social and health care system. In consideration of this group of patients as needing services that are well coordinated and comprehensive, ACT-teams should be a relevant offer for these patients. The study is part of a research based evaluation program the Norwegian health authorities has set up to investigate the functioning of a total of 12 ACT-teams established in Norway during 2009-2010.

Most addiction programs share an acute-care model of intervention, focused on symptom reduction and delivered within a short timeframe. A crucial question is whether persons with high personal vulnerability, high problem severity/complexity, and low recovery capital will benefit from sustained and assertive forms of monitoring and support. Dilemmas for personal recovery for patients included in ACT-teams include: How will their relation to legal and illegal substances influence the recovery process? How relevant is "Personal responsibility" when the patient don't see the need of treatment? Professionals focusing on empowerment versus compliance when working with patients. The importance of one-to-one relationships versus relation to a team. These dilemmas will be discussed.

Methods

A retrospective cohort study design with qualitative interviewing of selected persons (n=10) with simultaneous SUD and SMI included in ACT-teams, who have gained recovery after 12 months in treatment. A phenomenological/hermeneutic approach with data analysis through Grounded Theory.

Results/discussion

It is not possible to present results for the time being. By time of the Conference the interviews will be completed, as will also the data analysis. It will therefore be possible to present preliminary results from the study at the Conference.

Consumer satisfaction survey and its impact in community psychiatric rehabilitation services.

Tony Henderson, Michael Murabito

Introduction

Persons with co-morbid substance use disorder (SUD) and severe mental illness (SMI) are suffering from complex problems, and are in need of services from different agents and levels of the social- and health care system. In consideration of this group of patients as needing services that are well coordinated and comprehensive, ACT-teams should be a relevant offer for these patients. The study is part of a research based evaluation program the Norwegian health authorities has set up to investigate the functioning of a total of 12 ACT-teams established in Norway during 2009-2010.

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Methods

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Results/discussion

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Session 3.4 Mental health services and recovery

The REFOCUS Intervention: developing and evaluating a pro-recovery intervention for use within community based mental health teams

Mary Leamy, Victoria Bird, Clair Le Boutillier, Mike Slade, Julie Williams

Background/objectives

This paper will describe the REFOCUS trial and intervention, which is currently underway in two mental health trusts in the UK. The trial will evaluate whether service users in the intervention arm will experience significantly greater increases in measures of personal recovery, as measured by the Processes of Recovery Questionnaire (QPR) compared to service users receiving care from control teams.

The intervention comprises an 12 month team-level, pro-recovery intervention which will be provided in addition to standard care. It essentially involves two components: recovery-promoting relationships and three pro-recovery working practices: namely (i) Understanding the service user's values and treatment preferences; (ii) Amplifying a service users' strengths and ability to access community supports and (iii) Identifying personally valued goals, developing intermediate steps.

The intervention is supported by an implementation strategy which includes, Information sharing; Personal recovery training; Coaching and working practice training; Team manager reflection groups; Team reflection sessions; and Individual supervision reflection.

Methods

The REFOCUS trial is a cluster, two-centre, randomised controlled trial of a manualised recovery intervention which has been designed to be used within adult, community mental health teams. 15 out of the 29 trial teams will be allocated to the intervention arm and 14 teams will be 'treatment as usual' arms of trial. A randomised sample of 435 service users, who are aged 18-65 years, with a primary clinical diagnosis of psychosis and not currently receiving in-patient care will be assessed pre and post intervention.

Results

Early findings from the baseline stages will be outlined.

Discussion

The theoretical underpinning of the recovery intervention will be outlined and the complex issues surrounding implementing and evaluating recovery interventions with community mental health services will be discussed.

The REFOCUS intervention manual - using a hierarchy of evidence

Victoria Bird, Mike Slade, Clair Le Boutillier, Julie Williams, Mary Leamy

Background

Within the NHS, evidence-based medicine is still the predominant focus, with randomised controlled trials and systematic reviews seen as the gold-standard research designs within the evidence hierarchy. Although there is an increased drive towards recovery-orientated practice within the NHS, the recovery movement has been criticised for its lack of empirical evidence. The REFOCUS trial has been developed to specifically address this lack of 'gold standard' evidence in the recovery field. The manual and trial aimed to operationalise the processes and principles of recovery contained within the REFOCUS conceptual framework, e.g. empowerment (strengths-assessment), identity (Values and Treatment Preference Interview Guide), meaning and purpose (goal setting) and collaborative relationships (partnership project, coaching) Within both the manual and trial . Two examples of the working practices (Strengths-based Assessment and the Values and Treatment Preference Interview guide) will be discussed to highlight how the REFOCUS manual utilised different levels of evidence within its development.

Method

A systematic review was used to evaluate and select the best available strengths assessment for inclusion within the manual. This included assessing the psychometric properties of included measures and rating the assessments use within research. In contrast, the values and treatment preference tool was based on the results of a qualitative study which emphasised the person experience and perceptions of recovery for individuals who use services.

Results

The findings for two studies will be discussed, alongside how the different types of evidence were used in the development process.

Discussion

The value placed on different types of evidence and the tension that this creates particularly for recovery research will be addressed. The importance and contribution of different types of evidence to the development of the REFOCUS intervention manual will be discussed.

Rethink personal recovery training

Sally Gomme

Introduction

This presentation will outline the approach adopted by us in working with clinical teams in the intervention arm of the REFOCUS trial to help teams plan and deliver a pro-recovery intervention. The Rethink personal recovery training aims to facilitate the process of getting teams together to reflect upon their own recovery values, attitudes, knowledge and practice and to develop a shared team understanding of what a pro-recovery-oriented service is, and also, what it isn't. The Personal Recovery training sessions are also supported by externally facilitated reflection sessions with team leaders alone, and with individual multi-disciplinary teams.

This approach was originally piloted in the voluntary sector.

Rethink piloted the training in some of their own services and chose a range across the country. This gave us helpful insight into key areas of concern for the teams which included the practical difficulties of engaging whole teams, attitudes about the training (particularly for those that felt skilled in recovery already) and the perceived mismatch between what a recovery oriented service could achieve in the light of a restrictive context of organisational and statutory requirements. The pilot also helped us to recognise that all teams feel they are already working in this way even though this may or may not be the case, there is little consensus on the meaning and understanding of the approach. This is not to say that the work in the teams was not of high quality

Method

The training is co-facilitated by a professional trainer and a Rethink involvement worker, who has experience of living with mental health problems. There is a mixture of presentation, group work, exercises and discussion. The style is reflective and raises difficult questions for workers for example in the area of power in relationships and considerations of what does the worker become under this approach. Does it make workers feel de-skilled or re-skilled? What do organisations need to do to recognise skills in this approach?

Reflections

In this presentation we will share our experience of this work, what the challenges have been and what impact it appears to have had so far on participants' team values, individual values, knowledge, skills and behaviour.

Conclusions

We will outline recommendations for the use of personal recovery training with voluntary sector and to multi-disciplinary teams based in the National Health Service.

Coaching for recovery training

Sheena Bailey

Coaching is not therapy, it is an approach that helps people recognise their resourcefulness, take more control and set personal goals. This requires frontline staff to work differently, applying coaching skills in the clinical arena.

This presentation will outline the principles and method adopted by us in working with clinical teams to develop and embed a coaching approach.

Underpinning principles

- The individual is resourceful – and does not need to be 'fixed', or protected
- The role of clinical staff is to creatively challenge, hold to account and help the person make best use of their own resources
- The relationship is based on respect and equity
- Coaching is action oriented
- Coaching is about engaging the best in individuals and teams to achieve results

Method

Based on our experience, literature and research we have developed the **REACH**[®] approach (Reflect, Explore, Agree outcomes, Commit to action, Hold to account). The REACH method enables clinical frontline staff to reflect, think, act and follow through: encouraging a focus on whatever aspects are central to service users' personal goals. Using a REACH approach, staff work in partnership with

service users enabling them to gain a different perspective and take the decisions that help them get more of what they want in their lives.

Reflections

In this presentation we will share our experience of this work and its value for service users and staff.

Conclusions

We will outline recommendations for the use of coaching conversations in clinical practice.

Parallel Session 4

Session 4.1 Social rights and activism

Educational Initiatives as empowerment strategies for users and family members of individuals with schizophrenia in Sao Paulo, Brazil

Cecilia Villares, Jorge Candido de Assis, Jose Alberto Orsi, Fernando Pimentel

Introduction

Brazil is a country marked by important social inequalities, and many people with schizophrenia have their condition greatly aggravated by poverty, poor education, and social exclusion. Changing this reality requires a complex and sustained set of networking strategies. In such context, empowering those engaged in our anti-stigma strategies has involved the development of alternative discourses, practices and perspectives for people with mental disorders and their relatives, leading to social positions other than marginal places and roles in the community. The Brazilian Schizophrenia Association (ABRE), established in 2002 in São Paulo, Brazil, originated from an anti-stigma project that was part of WPA Global Program against Stigma and Discrimination Because of Schizophrenia. ABRE was constituted as a nonprofit civil organization co-led by consumers and family members, with mental health professionals as consultants and collaborators. Our main goal is to bridge science and promotion of human dignity of people affected by schizophrenia, proposing dialogue and empowerment as main strategies for social change.

Method

We will address key cultural aspects of the empowerment strategies employed in such a context of action, focusing on the Educational Initiatives through which ABRE, in partnership with the Schizophrenia Program of São Paulo Federal University, devised successful low-budget actions that can act as case examples to inspire similar initiatives in other countries.

Results

Learning's from our educational initiatives, based on the analysis of evaluation forms filled by the participants, and interviews with users and family members who have acted as activity coordinators, indicate that a recovery-oriented approach can be a powerful tool for helping people regain agency over suffering.

Discussion

We discuss the possibilities of including people with mental illness and their family members as stakeholders to design and deliver educational activities, and the effect of this strategies in generating user empowerment and improving social participation.

United to help movement (UPA) in Portugal: To combat mental illness stigma and promote mental health

Filipa Palha, Luisa Campos

The UPA-UNITED TO HELP MOVEMENT was initiated by ENCONTRAR+SE – Associação de Apoio a Pessoas com Perturbação Mental Grave, a non-profit, and non-governmental organization (NGO), founded in Portugal on Mental Health Day 2006. One of the main goals of ENCONTRAR+SE is to develop initiatives to fight stigma and discrimination against people with mental disorders.

Considering that mental health has never been a political priority in our country, no investment has ever been made in projects aimed at combating mental illness stigma and discrimination in our country. It was since the foundation of ENCONTRAR+SE that mental illness stigma started being studied, and anti-stigma campaigns developed in a systematic way. In October 2007, ENCONTRAR+SE started a consistent, continuous and creative movement, named "Movimento UPA 08– Unidos para Ajudar. Levanta-te contra o estigma e a discriminação das doenças mentais" ["UPA 08 - United to Help Movement. Stand up against stigma and discrimination towards mental disorders], which includes both national and local initiatives, aimed at raising public awareness, fighting stigma and promoting mental health.

This presentation will describe the rationale, strategy and outcomes of our first national anti-stigma campaign, which lasted for 12 months, and was based on music to convey the anti-stigma messages. It will stress the importance of using creativity to achieve two main goals: 1) help mental health/illness become a "visible" issue; and 2) attract people to an issue they tend to avoid/ignore.

UPA (United to help movement) makes a difference: A school-based intervention to promote mental health literacy and combat mental illness stigma in young people

Luisa Campos, F Palha, V Lima, E Veiga and P Dias

The “UPA faz a diferença” (UPA – United to Help Movement makes a difference) is a school-based project that has the main goal of promoting mental health amongst young people (15-17 year-olds). This project is based on a two-session intervention intended to be effective in enhancing knowledge, attitude and behaviour of young people in relation to mental health/illness issues. The materials of this project were developed in a creative way so that, together with the music developed for our national anti-stigma campaign (UPA 08), we can catch young people’s interest and engagement in a subject they tend not to be exposed to.

This presentation will focus on the main findings of the pilot study developed to understanding young people’s needs regarding mental health education; will discuss the methodology used and the materials developed for the project; and will present the preliminary results of the effectiveness of the project in raising young people’s mental health knowledge.

Session 4.2 Recovery and wellbeing

How to support self-directed recovery? Organisational lessons on the introduction of personalisation from four sites in the UK

Emily Ainsworth, Sue Patterson, Clare Holt

Introduction

Personalisation is a driver for modernising social care in England. Personalised care aims to empower people with social support needs, giving them the choices and crucially the funding, to purchase necessary support. In this respect, the mental health sector faces particular challenges, both due to the difficulties of integrating health and social care provision, and the fluctuating nature of severe mental illness. How are social care agencies meeting these challenges?

Methods

The People Study works across four sites in England, representing diversity in geography, demography, prosperity, and service composition. Study phase one involved 64 semi-structured interviews with representatives from Local Authorities, NHS Trusts, third sector service providers and service user led organisations. Additionally, researchers gathered local intelligence, becoming involved in networks, forums and information sharing events. A Lived Experience Advisory Panel, with representatives from service user organisations in each site, supports the study with local intelligence and national guidance.

Results

The data presented participants’ views on the current status and future prospects of personalisation of mental health care at site level, showing how personalisation was defined by local contexts. Each of the four sites Local Authorities introduced personalisation in variant ways, either proactively using it as an opportunity to accelerate ongoing service change or reactively seeking to ensure that minimal government targets were met, whilst existing systems remained operational. The sites used different approaches to engage active involvement of stakeholders and ensure their joint ‘ownership’ of the introduction of personalisation.

Discussion

The introduction of personalisation affected commissioning decisions, partnership working and service structures. Local engagement with the philosophy and practicalities of introducing personalisation was influenced by the wider political and economic climate. Our findings suggest that the local implementation was developed with reference to Recovery practice, and dependent on variant cultures and contexts.

Enabling wellbeing: working with women and providers in the context of domestic violence and mental health issues

Shulamit Ramon, Caroline Meffan, Linda Fallon, Michele Lloyd

EmpowerW is an action research project funded by the Daphne EU scheme, led by the University of Hertfordshire with academic and practice partners from England, Greece, Italy, Poland and Slovenia.

This action research project aims to apply the new meaning of recovery to these service users.

Although these women users often come with a high level of psychosocial needs to mental health services, providers tend to ignore the domestic violence (DV) aspect, thus giving the message that DV is a taboo topic in mental health services.

The project is focusing on:

- * introducing self management, well being, and being in control strategies to women experiencing these issues.
- * preparing some of the women to become co-facilitators of support groups.
- * increasing awareness, knowledge and skills of mental health providers who work with this group.
- * doing so by offering three training modules within an educational setting.
- * a systematic evaluation of pre and post programmes expectations, outcomes in key areas, and views on the value of the training.

Consultations with service users took place prior to the preparation of the modules. Modules were prepared by all partners, providing a multidisciplinary perspective complemented by that of service users', to ensure a good coverage of relevant experiences. Trainers too come from varied backgrounds (nursing, psychiatry, psychology, social work, service users) and service sectors (public (statutory), voluntary, university). Attention has been given to both content and format of the modules, aiming to have engaging and stimulating sessions which while focusing on discomforting issues, do so in a constructive, safe and caring way.

Preliminary findings from the project will be presented in terms of the light they shed on the introduction of the recovery wellbeing approach to this group and its service providers.

Development and evaluation of the five-language Clinical Decision-making Involvement and Satisfaction (CDIS) Measure

Harriet Jordan, Elly Clarke, Bernd Puschner, Mike Slade and the CEDAR study group

Background

Service user involvement in and satisfaction with decisions made in their care are likely to be important factors in their recovery. Clinicians and service users disagree as to who is more involved in clinical decision making. Service users tend to describe their experiences with decisions as being more paternalistic whereas clinicians see their decision making style as being shared. Because of these differences it is important to look at both viewpoints. How a service user feels about a decision influences their help-seeking behaviour and treatment compliance which has implications for recovery. Research into satisfaction in mental health care usually looks at the overall experience rather than satisfaction with a specific decision. In order to better understand clinical decision making it is necessary to develop a tool to measure the involvement and satisfaction with specific decisions. Our aim was to develop and psychometrically evaluate a measure assessing involvement and satisfaction in clinical decision in mental health with both service user and clinician forms.

Method

We undertook a literature review to identify self-rated measures of involvement and satisfaction and modified identified measures to produce a draft CDIS. Individual interviews and focus groups were undertaken in six countries (Denmark, England, Germany, Hungary, Italy and Switzerland) to ensure conceptual equivalence in the construct of clinical decision making. The draft CDIS was translated into each target language. A back translation was then made into English and reviewed by the London site. CDIS was then piloted at each study site and modifications were made to the final measure in line with findings. Further validation was then undertaken using data from 566 service users.

Results

Eight existing measures were identified, from which the Control Preference Scale and the Satisfaction With Decision-making scales were chosen and modified to produce staff-rated CDIS-S and patient-rated CDIS-P. The focus groups and interviews confirmed conceptual equivalence. Both CDIS-S and CDIS-P were piloted in the six study sites, and modified as needed. Psychometric evaluation of the measure investigated key aspects of validity, stability and feasibility.

Discussion

CDIS-S and CDIS-P assess involvement and satisfaction in clinical decision-making from the perspectives of staff and service users, and is available in Danish, English, German, Hungarian and Italian.

Users' experiences with Green Care Services

Bengt G Eriksson, Arild Granerud

Introduction

“Green Care” is a well known international concept, about the use of agricultural farms – animals, plants, vegetable gardens, forestry, landscaping and being in the nature – as a base for supporting mental and physical health, as well as quality of life, for a variety of client groups. Great many Norwegian farmers offer Green Care services to, among other groups, people with mental health and/or drug problems. The Green Care concept has in this study been interpreted in a recovery model, and the possibilities, when elaborating Green Care in combination with the tradition of recovery, will be scrutinized.

Methods

Individual qualitative interviews with 23 people, aged 19 to 62, with mental health and/or drug problems in a Green care setting was conducted during 2011. There were proximity like numbers of women and men. The interviews were analyzed with a modified Grounded theory method.

Results

Experience in working on a farm was essential to the individual's recovery process. Important factors were normal circadian rhythm, contact and work with animals, strengthened social ties and sense of coherence and meaning in life. Especially being in contact with animals was a rewarding but challenging experience, increasing self respect and personal growth. Working to cultivate in the open air and physical labor was essential. From the informants perspective participating in Green Care Services meant a significant step towards recovery.

Discussion

Does Green Care Services offer a new perspective of recovery? Should it be regarded an alternative, or a complement, to traditional mental health services? Does Green Care suit all categories of participants? Which are the strengths and limitations of this concept?

Session 4.3 Mental Health Services and recovery: Implementing change

The recovery journeys of professionals

John Good

This presentation will be based on the recovery journals submitted by students during a degree module concerning recovery principles and their application in practice. The students came from a broad range of settings including NHS older adult services, working age adult services, learning disability and forensic settings. In addition we also had people from the third sector and people using our services. The reflective journals document how the learning on the course change the students thinking and practice. Some demonstrate really innovative ways of working, others, simple things which can be put into place that make a real difference and cost nothing! All show the students journeys in terms of recovery orientated practice.

Strengths model brainstorming: Getting clinicians on board with consumer and recovery orientated conversations

Melissa Petrakis, Bridget Hamilton, Michael Wilson

Introduction

St Vincent's Mental Health is 6 years into a process of implementing the Strengths Model of Case Management into its specialist public mental health service. This paper features a change in practice by clinicians, when they meet as teams to discuss consumers and the work.

Method

One of three key elements within the Strengths model is the weekly, structured team discussion called Strengths Supervision. The process reorients traditional clinical team review conversations in several important ways. For example, focus is not backward-looking, to formulate around the cause of problems or failures. Rather, the bulk of time spent in team conversation is future oriented.

To monitor the implementation of Supervision, we sought feedback from facilitators and team participants in five teams, for every sessions provided over a ten week period, using standardised feedback forms, one for facilitators (N=27) and another for team members present (N=27).

Findings

Some staff were reluctant to engage in compulsory 'supervision' meetings. So, without changing the requirement to participate, the meetings were reframed as "Strengths brainstorming" and the

supervisor as “the facilitator”. Beyond this point, teams were enthusiastic in actual uptake of the meetings. Evaluation shows good fidelity across the range of recovery oriented features, such as “translating problems into goals” and “identifying client strengths”, and “group identified and celebrated successes”.

Discussion

In the sessions, case managers presented their work with clients and sought assistance to work in a still more strengths oriented manner. This was reportedly viewed as highly productive. Results for group interaction, client work, and the extent to which the case managers received the help they sought are highly relevant to fidelity with the Strengths model and important for monitoring implementation. The process of Strengths brainstorming is key driver of a recovery oriented culture in the service.

How “recovery” documentation can contribute to care planning

Gabrielle Richards, Simon Raynor, David Singer

Introduction

Historically, services have taken responsibility for writing the Care Programme Approach (CPA) care plans of individual service users. At best, service users have been consulted on the development of their care plans; at worst they have been written and service users report that they know nothing about them. This has been echoed in many poor national patient survey results, indicating that people did not have copies of their care plans or had not been involved in their writing. This paper will present the organisational approach that has led to the development of recovery-focused care plan documentation.

Method

Under the umbrella of the Trust’s Social Inclusion and Recovery Strategy (2010-15), a small working party was convened to develop recovery-focused care plan documentation. The working party drew upon clinical experience, best available evidence, good practice and, crucially, service user and carer views and experiences. The project took an integrated approach to developing the documentation, making sure that it firmly embedded the concepts of personal budgets and self-directed support.

Results

The process has generated recovery-focused CPA care plan documentation (as well as paper-based versions) that will be used by the whole organisation. The documentation allows for different drop-down menus and changes in language for different services such as Children and Adolescent Services and Older Adults. There is the intention that service users will lead the process and appropriate training and guidance will be produced for staff to support the process.

Discussion

Key to this presentation will be the personal reflections of the presenters on the development and implementation of the documentation. This will include discussion of barriers and enablers to the process. Attention will also be given to the next steps needed on this journey.

Social interaction and the importance of occupational factors: comparing day centres attendees with non attendees in Sweden

Elizabeth Argentzell, Christel Leufstadius, Mona Eklund

Introduction

Research has shown that social engagement enhances recovery for people with psychiatric disabilities (PD) and that many rely on community based services to get the support needed. Community based mental health services have a responsibility for providing social opportunities for people with PD, often in terms of day centres that also offer engagement in different kinds of activities. Research is, however, still scarce regarding the experience of social interaction among people who use such community based services. The aim of the study was hence to, in a Swedish setting, investigate whether or not community based day centre attendees differ from non-attendees regarding different aspects of social interaction and to investigate how factors pertaining to everyday activities, including day centre attendance, and previously known predictors were related to social interaction in the study sample as a whole.

Method

93 day centre attendees and 82 non-attendees were examined regarding social interaction, subjective perception of occupation, activity level, sense of self-mastery and socio-demographic and clinical variables. Data were analysed with non-parametric statistics, mainly logistic regression.

Results

For the group as a whole social support was mainly provided by informal caregivers such as family members. The day centre attendees had more social relations but did not experience better quality or closeness in their relationships than non-attendees. Important factors for social interaction were subjective perceptions of daily activities, being married/cohabiting, self-mastery and severity of psychiatric symptoms.

Discussion

Alternative ways of enhancing social engagement and recovery in the community based mental health care in Sweden are needed, among other things should the participants' feelings of satisfaction, value and self-mastery in daily life be targeted.

Session 4.4 Mental health services and recovery: implementing change

Developing creative ways of involving older people and their carers in developing and changing service delivery

Nuala Conlan, Stephanie Daley, Lynda McNab, David Newton

Introduction

Whilst the impact of the recovery philosophy and related inclusion initiatives upon mental health services for working age adults has been substantial, similar research and developments in older people's mental health services are limited. Older people with mental health problems have been shown to respond to the Involvement agenda and different strategies are required to take this work forward. This presentation will explore our work in this area.

Methods

We are establishing advisory groups comprised of service users, carers, and local agencies, to build more trust with all stakeholders, as relationships need to be nurtured, sustained and meaningful as time passes. We are using fun, conversations, celebratory events, and other mechanisms to get our communities together – sharing stories and their understanding of mental health and recovery.

Results

There are quite distinct challenges in older adults that do not present in working age adults. Issues such as their concept of time – many activists want change fast as they feel they want to see it in their lifetime. Others include preparation and development time, frailty, payment, transport, involvement of ex-carers, CRB and occupational health checks to name but a few. Probably the greatest challenge faced by people wanting to get involved is age discrimination as well as staff attitude to risk.

Discussion

What do we need to do to get beyond the rhetoric and fully include older people in the development and delivery of our mental health services? How do we work together to change our involvement structures and power differentials in order to engage older adults as equal partners in our mental health services?

Delivering a Team-based Recovery Training Intervention in Older Adult Mental Health Services

Lynda McNab, David Newton, Nuala Conlan, Stephanie Daley

Whilst the impact of the recovery philosophy upon mental health services for working age adults has been substantial, similar developments and research in older people's mental health services is limited. The Older People's Mental Health Service within the South London and Maudsley NHS Foundation Trust has sought to:

- Identify which components of recovery are valued by older people with mental health problems, including those with dementia.
- Understand the clinical practice implications and to develop and deliver a recovery training package for staff to support a change in service delivery.
- Undertake a formal evaluation of the impact of recovery training upon service users and staff.
- Develop creative methods of involving older people and their carers in changing service delivery to become more recovery-oriented.

The aim of this presentation is to describe the iterative development of the recovery training package, and to present some of the preliminary results

Methods

The four-day team based recovery training package has been delivered to clinical staff working within 14 clinical teams, including community mental health teams, in-patients units and specialist memory and continuing care units in South London.

A formal evaluation of the impact of the training on is being undertaken which includes both quantitative and qualitative methodology. The specific research objectives are:

- To evaluate the impact of delivering a team-based recovery training package upon staff attitudes, knowledge and practice.
- To identify the blocks and enablers in moving towards recovery-orientated practice at individual and team level within older people's mental health services.

Results

The team based recovery training package has successfully improved staff knowledge and attitudes about recovery. Considerable variation has however been noted in the extent which individual teams have been able taken forward team level change in implementing recovery-oriented practice. Factors which appear to influence the outcomes have included the presence or absence of recovery 'champions', team dynamics, organisational ownership, competition with other initiatives and change fatigue.

Discussion

Team based recovery training would appear to a successful method of implementing recovery-oriented practice, but the strategies which address the organisational culture of individual clinical teams need to be identified.

What are the implications of personal recovery for older people's mental health services?

Stephanie Daley, David Newton, Joanna Murray, Mike Slade, Sube Banerjee

Background

Whilst the impact of the recovery philosophy upon mental health services for working age adults has been substantial, similar developments have not yet taken place in older people's mental health services and research in this area is under-developed. The older people's mental health service within the South London and Maudsley NHS Foundation trust has sought to:

- Identify which components of recovery are valued by older people with mental health problems, including those with dementia.
- Understand the clinical practice implications, and to develop and deliver a training package for staff to support a change in clinical practice.
- Undertake a formal evaluation of the training upon service users and staff.
- Develop creative ways of involving older people and their carers in changing service delivery

The aim of this presentation is to present a conceptual framework for recovery and older people, and to introduce a model of intervention.

Methods

Qualitative interviews have been carried out with 28 users of older peoples' mental health services and 10 carers in order to develop a framework for recovery and older people. The findings from the qualitative interviews have been used to facilitate three focus groups of service users, carers and clinicians in order to develop a model for recovery-oriented practice for peoples' mental health services.

Results

The experience of recovery for users of older peoples' mental health services differs in that it appears to be primarily concerned with maintaining or regaining a sense of pre-illness identity. Key coping strategies appear to relate to the continuity and adaptation of existing social supports, valued social roles and meaningful activities. For people with dementia, the subjective experience of recovery changes over time, and spousal carers having a pivotal role in facilitating or hindering the opportunities for recovery to take place.

Discussion

Personal recovery does have resonance for older people, including those with dementia. There are substantial practice implications arising from these findings for older peoples' mental health services, which differ significantly from those which affect working age adult services

How can we measure the recovery of Users of Older Peoples' Mental Health Services?

David Newton, Lynda McNab, Nuala Conlan & Stephanie Daley

Background

Whilst the impact of the recovery philosophy upon mental health services for working age adults has been substantial, similar developments are only just beginning to develop within older people's mental health services and research in this area is under-developed. From a qualitative study undertaken in 2010, the experience of recovery for users of older people's mental health service would appear to relate to the extent to which pre-illness identity can be maintained or regained following an episode of illness. A number of specific components of recovery have been identified as being meaningful. This presentation will describe the work undertaken in identifying and using recovery measures for older people with mental health problems, and some of the challenges experienced

Methods

The following recovery measures have been piloted with users as they appeared to include components of recovery which are meaningful for older people within mental health problems.

- Developing Recovery Enhancing Environments Measure (DREEM) (Ridgeway 2004).
- The Mental Health Recovery Star (McKeith & Burns, 2008).
- Illness Management and Recovery (IMR) Scale (Meuser et al, 2004).

Results

Existing measures of recovery developed for working age adults would appear to be unsuitable for users of older peoples' mental health services, due to the following reasons:

- Some components of recovery within existing measures of recovery would appear to have little value to older people
- Language used within existing measures
- Reduced awareness of personal difficulties for people with dementia

Discussion

Older peoples' mental health services will need to respond to the recovery agenda, and in doing so, they will need to develop measure components which are valued for older people. How best to develop measures which obtain the views of service users with advanced dementia remains a significant challenge both in terms of validity as well as fidelity to the recovery philosophy.

POSTER PRESENTATIONS

Poster 1. Green Recovery – On the integration of Recovery, Green Care and User Perspectives Rita Agdal, Ragnfrid Kogstad, Jan Kaare Hummelvoll, Mark Hopfenbeck

“Green Care” refers to the use of nature, animals and farms to support mental and physical health and quality of life. In Norway several governmental agencies take part in the development of Green Care, including, amongst others, the Department of Health, the Department of Agriculture, and the Department of Work and Welfare. Green Care is offered to various groups, but here we focus on Green Care services for people experiencing mental problems or problems with alcohol and substance abuse.

Methods

Central policy documents and reports (26), mainly from departments and governmental agencies, were analyzed to identify political intentions and conceptualizations with regard to “Green Care”. Furthermore, we analyzed how “Green Care” is conceptualized as an alternative or supplement to existing services in line with a recovery orientation.

Results

In the policy documents there is a positive interest in Green Care, particularly related to farming, and a common understanding of a need for alternatives for the groups in focus. The agencies have different intentions for the development of Green Care and it is conceptualized in various ways related to their different primary tasks; as health promotion, as a preparation to take part in the labor market, and as a niche product for farmers, amongst others. The recovery perspective is not prominent, as labour market participation is a main theme and few reports take users perspectives into account.

Discussion

The different conceptualizations and intentions of agencies engaging in “Green Care”, and the implications for the development of Green Care services are discussed. Furthermore we discuss to what extent the agendas of different agencies may be conflicting, and suggest changes necessary to integrate a recovery and user perspective. The integration of user perspectives and a stronger recovery orientation seem necessary to develop Green Care into a relevant alternative for the group in focus.

Poster 2. The role of the Ombudsman at PROESQ – Schizophrenia Program of UNIFESP (Federal University of São Paulo)

Jorge Assis, Cecília Cruz Villares, Rodrigo Affonseca Bressan

Introduction

The Schizophrenia Program (PROESQ) established in 2011 its Ombudsmanship. The initiative is a result of the process of empowerment and protagonism of its users and professionals, implemented in a consistent way through the years. The ombudsman must understand the perspectives of the users and the perspectives of the team, and can exercise this responsibility, through dialogue and mediation, guided by actions validated by the service.

The current ombudsman is a person with schizophrenia who was a user of the Program for two and a half years, and in 2008 was invited to integrate the team. He is supported by the service users, staff and coordinators to effectively consolidate the Ombudsmanship.

Methods

Application of the Satisfaction Scales with service users, in addition to the survey, the Ombudsman will schedule individual appointments and a Suggestion Box will be available for written contributions. The professionals will be informed of the scope of activities of Ombudsmanship, to invite its utilization and to inform the users about the ombudsman practices.

Results

The results of the Ombudsmanship in the current phase is to disseminate new concepts between the users and professionals: through dialogic practices, contribute for the consolidation of the values of citizenship and to diffuse through the practical actions the concept that everyone can collaborate to improve the services received and given, as well as the activities developed at PROESQ.

Conclusion

The Ombudsmanship is an initiative that has developed together with the process of organizational restructuring of PROESQ, and it is directly linked to the Deliberative Council of the Program. It has the function of hearing and to the demands and internal suggestions. It also has the role to represent PROESQ in the matters related to advocacy, community issues, Public Power, and Law operators. This is a pioneering initiative in mental health in Brazil.

Poster 3. Life Changes among individuals participating in an Individual Placement and Support (IPS) program

Cecilia Areberg, Tommy Bjorkman, Ulrika Bejerholm

Introduction

Recovery among people with severe mental illness is a process towards enhanced participation and experiences of quality in life. The vocational program the Individual placement and support (IPS) approach is known to have a favourable impact on different vocational outcomes. In comparison, less is known about IPS impact on participants' time use assessed engagement in daily life and quality of life. Our research question was: Does IPS enhance level of engagement in daily activities and community participation, and quality of life among people with severe mental illness, and in comparison to those receiving traditional vocational services?

Methods

120 participants in a randomized controlled trial, comparing IPS with traditional vocational services, were administered Profiles of Occupational Engagement in People with Severe Mental Illness (POES), and the Manchester Short assessment of Quality of Life (MANSA) at baseline, six and 18 months.

Results

Changes in general life satisfaction ($p=0.002$), satisfaction with work situation ($p=0.000$), economy ($p=0.033$), number of friends ($p=0.001$), and mental health ($n=0.009$) was found among the IPS participants, from baseline to 18 month follow-up. At 18 months the QOL among the IPS participants differed significantly ($p=0.002$) from the participants receiving traditional vocational service. During the study period increased level of daily activities and community participation was also found among the IPS participants ($n=0.012$). No such change was found among the participants receiving traditional vocational service.

Discussion

The results suggest the IPS approach to have the potential to enhance the quality of life of people with severe mental illness, and to fulfill its secondary goal, namely that to enhance social integration, experiences of connectedness to the neighbourhood, and local community among people with disabilities. Thus, the IPS approach seems to play an important role in the recovery process of people with severe mental illness.

Poster 4. Developing a recovery focused, evidence and theory based multi-disciplinary clinical model of care for an acute older persons mental health service

Alison Bullock, Sarah Dexter-Smith

Introduction

A clinical model of care has been developed for an older person's inpatient unit. This is underpinned by the concepts of hope and recovery. It uses cognitive behavioural formulations as a means of drawing together user led needs identification and multidisciplinary assessments following admission. This aids understanding of the individual's presentation and experience and collaborative planning of and support for the person's recovery.

Method

Best practice philosophy and theory were shaped into a single working model and training packages developed or purchased to support its implementation. Training was delivered to all staff members, and MDT members, wider management, and clinical support staff were consulted on the draft model of care during its development. Consultation took place via formal meetings and during delivery of the training plan, with particular emphasis on the skills and attitudes required by staff to support and deliver the final model of care. Clinical tools were developed to help staff translate their learning into practice, including tools which are patient owned.

Results

A single model of care has been developed which;

- Is based on concepts of and positive attitudes towards recovery.
- Is underpinned by individual cognitive behavioural formulations.
- Promotes a better understanding of each individual patients needs and behaviour.
- Encourages more effective MDT working.
- Promotes the specialist skills of staff.

Discussion

The initial model of care has been revised twice. Significant training has taken place, and formulation groups are established. The use of interactive recovery focused poster sheets owned by the patient has begun. At present, links between the use of recovery focused tools and cognitive behavioural formulation are being further established to strengthen the level of individualised intervention taking place. Implementation of the model in practice will be supported over the next year prior to further review in 2012.

Poster 5. The use of interactive recovery posters in an older persons in-patient service

Alison Bullock, Helen Hinnigan

Introduction

Staff on an older persons mental health ward completed the NIMHE 10 Essential Shared Capabilities recovery training. During training, the post crisis planning section of the WRAP was identified as most pertinent to the post admission stages of a patient's journey. Engagement in this element as a starting point during admission has therefore been prioritised (although patients are encouraged and supported in any aspect of their WRAP).

Methods

Three diagrams into which patients can enter their answers to specific questions were developed based on the post crisis recovery plan. These diagrams have been developed into a poster sheet which is available in each patient's room and can be written or drawn on by patients at their own pace and choosing. Very small amounts can be completed or larger areas, and with permission/in collaboration, family and friends and ward staff of any grade can also participate.

Results

The use of these interactive sheets is currently being monitored and evaluated. Qualitative feed back is available via the feed back section on the sheet itself. Patients will also be approached to clarify how useful (or not) they found the sheets. Completion is monitored daily in relation to how much and which sections are completed, how often patients choose to take the sheets to discussion meetings with ward staff, and how many of the answers are used to help form intervention plans with patients.

Discussion

It is envisaged that initial discussion around the aims below will be possible following use of the interactive sheets for a period of three months.

- Encourage patients in planning and leading their own recovery.
- Promote a recovery based culture of care.
- Assist with the formation of specific intervention plans which support recovery as identified by patients.

Poster 6. The role of research centres in increasing service user involvement, networking and activism: RCOMH as an exemplar

Wendy Bryant, Katrina Bannigan, Jacqui Lovell, Anthony Jones

Introduction

It is acknowledged that "we need to listen to the voices and stories of those with direct experience of mental illness/ madness...They can reveal that it is possible to live through the turmoil of mental distress" (Campbell 2006: 9). There is an expectation that service users will be not only be involved in research but that "...if done well it should provide better research and enhanced implementation of findings" (RCN 2007). Although service user involvement is a laudable aspiration there is a continuum of 'involvement' with a danger of tokenism. "A research group that tacks on someone from the 'outside' because it is politically correct to do so is not inclusion. This is tokenism." (Steel 2004: 3). The way to avoid tokenism is to change how we behave as researchers.

Objective

To explore how service users have shaped the Research Centre for Occupation and Mental Health (RCOMH).

Description

RCOMH was developed to increase research into occupation and mental health. Its formation was prompted by Recovering Ordinary Lives (COT 2006) which in turn was informed, in part, by service user research. A service user consultancy, developing partners, is one of its founder members and two of its members are steering group members. The formation of, and a study conducted by, RCOMH will be presented as an exemplar of how research centres can increase service user involvement, networking and activism.

Discussion

Service users have encouraged a language of participation, capacity building and empowerment. This is observed in RCOMH service user and carer involvement in research policy and was enacted in the EAGER project, a research study which involved service users as researchers and participants.

Conclusion

The development of RCOMH illustrates that research centres can avoid tokenism and increase service user involvement, networking and activism.

Poster 7. Implementation of IPS in a Swedish welfare system: A case study

Ulrika Bejerholm, Lars Larsson, Caisa Hofgren

Introduction

The implementation challenges of Individual Placement and Support (IPS) vary across countries and contexts. In Swedish national guidelines IPS is recommended. However, no implementation evidence of IPS exists with regard to the Swedish welfare system, including the Health and Community Care, the Social Insurance Agency (SIA) and Public Employment Service (PES) organisations. This study aimed to illustrate IPS in a Swedish welfare system and the implications for IPS delivery.

Method

An embedded case study design was conducted, which is suitable to employ when the boundaries of a known phenomena (IPS), and the context (Swedish welfare system) is not well known. Interviews, documents and audio materials, concerning participants and professionals involved, were collected for 18 months. A content analysis was used.

Results

The participants' path through the welfare system was determined by them having certain benefits, and regulations of the SIA and PES. As a consequence, IPS could deviate from its course, and be put on hold. The first four IPS-principles, concerning a self-chosen, rapid and personalized search for work, were reported difficult to implement. Lack of knowledge about mental illnesses and a caring perspective instead of a recovery one were presented as other obstacles. Moreover, the participants' ability to work with IPS-support was not valid as compared to the formal work capacity evaluations at SIA and PES.

Discussion

The discussion sets out recommendations, that 1) IPS is recommended to all welfare organisations, 2) the ability to work with support becomes a valid form of evaluation of work capacity in welfare services, 3) vocational services becomes personalized, 4) professionals in welfare services get to meet persons with mental illness that work and 5) take on a supportive role instead of an expert one in their day-to-day interaction, 6) and previous to IPS implementation ensure service commitments from all actors.

Poster 8. Psychiatric Ward Rounds in a Locked Rehabilitation Unit: An Evaluation of Patient Perceptions

Shereen Brifcani, Louise Stevenson

Introduction

Ward rounds are one of few forums where information is shared, and important decisions made with the MDT and patient. However, they can be experienced as unpleasant by patients. Intrinsic and extrinsic factors influencing ward round satisfaction are reported. The extent to which evidence is actually used to influence practice and the extent to which the recovery approach is operative are questionable. As such, patient perceptions of ward rounds at a 17-bedded locked rehabilitation unit were evaluated. The Recovery Approach is the underlying philosophy, and the current study evaluated views of patients to develop, implement and review recommendations.

Method

Structured interviews were conducted with 11 participants by an assistant psychologist or independent advocate. A literature review and staff observations informed questions. Areas evaluated were: understandings of ward rounds; practicalities; usefulness; and feelings. Following collection and analysis of interview data, recommendations were made and implemented. After six months, interviews were conducted again, and recommendations made.

Results

Mixed reviews were provided by participants. Strengths of the existing ward round and areas of improvement were identified. Recommendations included: ensuring that patients felt listened to at all times; reducing feelings of anxiety and intimidation prior to and during ward rounds; increasing patients' ability to self-evaluate through decreasing reliance upon staff feedback / increasing useful

questioning; addressing power-differentials; increased patient inclusion in ward round processes. The process of implementing the recommendations was reviewed.

Discussion

The study highlighted not only patient perspectives of ward rounds, but also the process of implementing change. The shift of approach from medical-oriented to a recovery-oriented required a change of staff attitude / philosophy in order for the shift to be sustained and effective. The service is likely to continue to evolve, aided by on-going evaluation of ward rounds. Generalisation of results to other meetings / clinical practices is considered.

Poster 9. CEDAR study: Factors associated with decision implementation in severe mental illness

Elly Clarke, Harriet Jordan, Bernd Puschner, Mike Slade and CEDAR study group

Introduction

In the course of treatment for severe mental illness service users and clinicians will negotiate a multitude of decisions along the journey of recovery. How these decisions are made and the impact the decision making process has upon outcomes is being studied in the multi-national CEDAR study. The associations between desired and actual clinical decision making style and involvement; service user satisfaction with the decision and decision implementation have not been empirically tested.

Methods

588 participants from six European countries (Denmark, Germany, Hungary, Italy, Switzerland and UK) were included in the CEDAR (prospective observational) study. Data on decision making (collected using the Clinical Decision Making Style – Service User Questionnaire (CDMS-P); Clinical Decision Making Style – Staff Questionnaire (CDMS-S); Clinical Decision-making Involvement and Satisfaction – Service User (CDIS-P) questionnaire) and satisfaction (as rated on the CDIS-P questionnaire) were collected from staff and service users. Two months later implementation of the decision was assessed (using the Clinical Decision-making in Routine Care – Service User (CDRC-P) assessment tool).

Results

Results will be presented investigating the relationships between decision making involvement, satisfaction and implementation.

Discussion

Relationships between decision making involvement, satisfaction and implementation can inform clinical interactions to maximise recovery.

Poster 10. A tool to increase share and participation in mental health care. The Shared Care Paths

Barbara D'Avanzo, Renzo De Stafani, Stefania Arici, Paola Bertotti

The Shared Care Paths (SCP) are developed in the mental health service of Trento, Italy, to accompany and shape the mainstream clinical activity in a way that enhances sharing, reciprocal collaboration and equality between the various actors – user, family member, psychiatrist, other professional – in agreement with recovery and empowerment values.

In their current form, the SCP are used with users diagnosed with serious diseases and are conceived as five contracts around essential dimensions of care. The actors are expected to sign their engagement on the settled points, but everybody is free not to sign. The guarantee, a family member or a user formally collaborating with the service as rewarded peer supporter, explains why and how to use the SPC; checks times for the regular use of the SPC; symbolically represents the third party in the clinical relationship.

The contracts are about: 1. relationship as the dimension of respect, reciprocal listening, sincerity and openness; 2. definition of the individual treatment plan: aims carefully defined according to shared procedures; 3. drugs: more and clearer information and communication, increased attention to side effects; 4. how to be prepared to a crisis: how to be aware of signs, who has to do what to prevent the crisis or reduce its impact; 5. how to manage a crisis according to the user's wishes: setting and treatment preferred or deemed as most suitable; whom to ask for help and support. The group revises the accomplishments every six months, confirming or modifying reciprocal engagements and aims. Quantitative and qualitative analyses of the 148 SCP have been conducting to assess group characteristics of the most and least successful SCP; different points of view of the actors about the usefulness and most appreciated contracts, users' and family members' wellbeing improve! ment; impact on professionals' role and identity.

Poster 11. Illness Management and Recovery: a recovery-oriented approach in the staff teaching

Helle Stentoft Dalum, Lene Falgaard Eplov, Harry Cunningham, Inge Kryger Pedersen

Background

During the period of 2011 to 2012, the Illness Management and Recovery (IMR) program is being implemented in community mental health centres in Denmark. IMR is a nine months recovery-oriented intervention that uses a weekly group session format aimed at helping people with severe mental illnesses to set goals for their lives, gain illness self-management skills and thereby contribute to their own recovery. Staffs with case management responsibility are being educated in the concept of IMR and they are integrating the IMR practice into their usual daily work. The aim of this study is to explore the experiences of those staff in a qualitative design, particularly the ways that the recovery-oriented approach derived from the IMR program is potentially reflected in their work.

Methods

A pilot study consisting of in-depth interviews with clients, practitioners and administrators will be conducted at three community mental health centres in New Hampshire, USA. Themes related to the influence of the IMR practice on staff attitudes will be identified. Those themes will then be used to study ways in which a recovery-oriented approach is reflected in Danish mental health professionals using the IMR practice.

Analysis

The empirical material will be transcriptions of a number of qualitative interviews with staff, along with field notes. The analysis will be conducted using the principles of grounded theory.

Discussion

It will be discussed whether a program like IMR can be a tool in creating a recovery-oriented approach in community mental health care and which changes the teaching staff ascribe to the IMR program in their work of supporting people with mental illness. This knowledge will most likely be useful in implementing IMR or similar interventions elsewhere.

Results

The results of this study will be presented in 2012.

Poster 12. Testing the validity and reliability of the Recovery Assessment Scale using a Brazilian sample

Tiago Ribeiro da Silva, Cecilia Cruz Villares, Rodrigo Afonseca Bressan

The concept of recovery in mental health has been understudied in Brazil, but it's already a model and a movement of great importance in countries like USA and in Europe, studied primarily with schizophrenic patients. Researchers and patients have created and driven devices and instruments that guide professionals and mental health services to assist their patients toward recovery. Among the instruments of recovery, there is the Recovery Assessment Scale (RAS). This scale has 41 items, focusing on four categories: self-esteem, empowerment, social support and quality of life, and it had Cronbach's Alpha = .93. Currently in Brazil, there is no recovery instrument translated and validated into Portuguese yet. This paper presents the preliminary results of a master's project focused on the reliability and validity of the instrument RAS. This project includes a study of PROESQ - Schizophrenia Clinic of UNI! FESP (Federal University of São Paulo). The application of the instrument was performed in 104 patients that agreed to participate and signed a consent form. The RAS was translated and back translated, receiving a semantic and cultural adaptation to Portuguese. To validate this instrument others instruments that correlate with the measurements assessed by scale were administered: WHOQOL-bref; Inventory Independent Living Skills, Self-Assessment Questionnaire of Occupational Functioning, scale of the Positive and Negative Syndrome-PANSS. It is expected that the RAS will be validated and demonstrate itself reliable for measuring the process of recovery of patients with schizophrenia in the Brazilian context. From the validation of the RAS in the Brazilian context, strategies can be developed with professionals, to insert it to the daily work of mental health services because it is a useful, unique and easy to use instrument, capable to develop practices that help patients in ! their recovery process.

Poster 13. Recovery through engagement in mental health anti-stigma movements? Feedback from the Time to Change/ Open Up service user conference as an example

Bettina Friedrich, Sara Evans-Lacko, Graham Thornicroft

Introduction

Mental health stigma is a major barrier to recovery for people with mental health problems by harming their self-esteem. Many anti-stigma campaigns therefore do not only aim at increasing knowledge and improving attitudes among the broader public, but also enhancing wellbeing and empowerment among people who might be targeted by stigma. The Open Up project from England's nation-wide Time to Change anti-stigma campaign mainly engages people with mental health problems in the fight against mental health stigma and subsequently contributing to their well-being, empowerment and recovery. This study investigated the impact of the annual Open Up conference on the campaign supporters.

Methods

Conference attendees of the 2010 Open Up conference in Birmingham were asked to fill in a questionnaire. Data collected included: i) socio-demographic data, ii) experiences of mental health discrimination, iii) willingness to disclose, iv) awareness of other Time to Change campaign projects, v) conference evaluation and vi) impact of the conference on confidence and connectedness. In addition to this an open question encouraged participants to give additional feedback. 96 participants returned the survey.

Results

Survey results showed that people felt positively influenced in their confidence and helped them to get connected with other people with mental health problems. Participants rated the quality of the event highly and would recommend this event to a friend.

Discussion

The survey data shows the conference impacted positively on the confidence of the participants, indicating an achievement with regard to their recovery. Future research will be compare these findings with data from other Open Up projects in terms of specific contribution within the context of the wider campaign. Conclusions will be drawn to the role anti-stigma campaigns can play to the recovery of people with mental health problems.

Poster 14. Tea and Talk: Reaching out with Recovery: connecting with wider society

Helen Hutchings

Tea & Talk is a local expression of the national Time to Change anti-stigma campaign. It consists of a series of 1 hour informal workshops facilitated by people who have both personal and professional mental health expertise who have delivered workshops to a range of business, educational and community settings across Devon.

The project is an expression of recovery values that aims to get alongside people emphasising the value of meaningful conversations and more open relationships in promoting mental well-being. Over tea and cakes, people are encouraged to realise that mental health is everyone's business and guided to think about their attitudes, to explore their knowledge, using a quiz, and consider how their actions can promote well-being for themselves and others to prevent and reduce the impact of mental distress.

People are given the opportunity to reflect on their own experience and to think about how it is in everyone's interest to work together for mentally healthier communities.

Evaluation of the project (Ley, 2010) found that people gained greater awareness and new knowledge. People particularly enjoyed the discussions with other members of their group and found the quiz very thought provoking, expressing surprise and shock at some of the statistics.

Through personal pledges people demonstrated that they understood the value of conversation and relationship in supporting both their own and the mental health of others.

Participating organisations have since reported greater confidence in taking steps to support, as opposed to manage, those who may be experiencing mental distress.

Tea & Talk has inspired and empowered some participants to "come out" with their Lived Experience, and use it as an asset in creating mentally healthier communities.

I will review our experience to date, lessons learned and make suggestions about promoting recovery values to foster cultural change within the general population.

Poster 15. Reconnecting to Recovery

Mark Hopfenbeck, Micheal Fraiss, Rita Agdal, Ragnfrid Kogstad

Introduction

According to Kartalavo-O'Doherty and Doherty (2010) there is currently no coherent theory of mental health recovery which can guide clinical practice. There is, however, a great deal of research being done which aims to develop such a theory. In our view, and in accordance with Bentall (2003), such a theory should allow us to both understand and explain the experiences of persons whom are mentally ill while accounting for mental illness and recovery in terms of processes that are important in everyday life. As part of an ongoing project aiming to develop recovery-oriented green care services we are developing a model which fulfills such criteria.

Methods

Major databases were searched using selected key words to find relevant studies concerned with theoretical models of recovery as well as of green care. Selected studies were summarized, then analyzed and discussed.

Results

A preliminary model was developed based on the recurring themes associated with the conceptual clusters of power/control/autonomy, status/worth/esteem and trust/security/hope. Central to the processes involved was a sense of reconnecting through the forming of meaningful relationships and affective bonds to oneself, to others, and to the natural world. These processes of reconnecting were generally characterized by expanding networks of reciprocal exchange.

Discussion

Well-developed green care may be especially conducive to the process of recovery given the factors described here. The caring for of animals, mastering manual tasks, participating in collaborative activities, feeling part of a natural environment, extensive peer-support and the presence of positive role-models within a context of person-centred services may all make unique contributions towards personal recovery and a sense of well-being.

Poster 16. From Guilt and Shame into a Life of Meaning and Purpose Recovery of Families Dealing with Mental Illness in the Family

Mazal Landes

Personal recovery is a process that can be best judged by the person himself. Recovery means a meaningful and satisfying life with mental illness (Mike Slade – 2009).

Recovery does not mean a "cure", but rather a way of life in which a person aspires to achieve their potential, while constructing a personal and social identity, and recognition of limitations. (Anthony, 2000).

ENOSH - the Israeli Association for Mental Health and MILAM (counselling centres for families with mental health) has developed and implemented innovative principles of family healing involving a holistic approach to the different and changing needs over time, that every one of the various family members goes through in the process of escorting and coping with the mentally ill family member.

Observation of the family, through the values of recovery, allows the construction of a sequence that enables the family member to choose the right place for himself at any given time while constantly changing his position from a family member in need of support to an empowered family member, respected by himself and his surroundings, capable of making personal choices to become an active part in his own recovery and a proactive leader in the recovery of other families.

The emphasis is on the unique abilities of each family member to develop a meaningful and personal being with an emphasis on the principles and messages of the recovery approach. This includes, ones sense of meaningfulness; affected by ones emotions, perceptions, personal expertise, personal choices, responsibility, hope, empowerment, etc.

The family counseling model involves various interventions that allow family members to engulf upon a process of personal recovery. This view takes into account the different needs of various family members (mother, father, brother, spouse, son) and the various conflicts characteristic of their specific role while understanding each ones personal life tasks and need for loyalty to one's self.

Family members can select from one or more of the variety of options at their disposal to help cope with the various challenges: from a one-time meeting (individual, couple, or family), to the decision to be an active social leader.

The lecture will discuss how the family recovery model is implemented and examples from the field will be illustrated.

Poster 17. Individual placement and support: from social exclusion to work – what support is required?

Ann Lexen, Caisa Hofgren, Ulrika Bejerholm

Introduction

Work is the hearth of recovery for many people with severe mental illness since it promotes both social relationships and a connection to society. Although the effectiveness of Individual Placement and Support (IPS) has been well established, not all people with severe mental illness benefit fully from the intervention. The components of the IPS-support may be important factors to consider in relation to job tenure and employment success and requires further investigation. Accordingly, this multiple case study aimed to investigate the support process in the IPS-approach from individual client and longitudinal perspectives.

Methods

Five IPS-participants, or cases, with severe mental illness who worked a minimum of 4 hours a week entered the study. A multiple data collection method was used over a period of 12 months and included IPS-vocational profiles and plans as well as various instruments and questionnaires concerning socio-demographics, work performance, limitations, and accommodations. Both within- and across-case analyses were performed.

Results

The IPS-process concerned job-search support, job-matches, and adjustment of the match by providing accommodations by on- and off-worksites support. All participants had limitations concerning social interactions and handling symptoms/tolerating stress. Several accommodations were made for the same limitations, mostly directed towards the social environment. Prior work experience, disclosure, and not being in an acute phase of illness seemed important to the support provided.

Discussion

A severe mental illness brings about disabilities that are difficult to detect at first. These disabilities are often hidden limitations that affect many aspects of daily life, including work. This study has visualised the support process in IPS to better detect limitations and provide IPS-support. The organization of IPS-support and methods of providing it to individuals may be important for job tenure and employment success.

Poster 18. Rehabilitation Support Services in the Hospital and Community enhances patients' recovery process

Saifudin Maarof, Eu Pui Wai, Margaret Hendriks

Introduction

At the Institute of Mental Health, a large tertiary hospital in Singapore, patients recovering from their acute phase of illness are encouraged to attend an 8 week rehabilitation program prior to their discharge. This is to enable them to integrate well into community living. As Anthony (1993) states "living a satisfying, hopeful, and contributing life even with limitations caused by the illness is an important goal for patients."

Methodology

Data mining on clinical outcomes was made for patients who were referred for the rehabilitation program 1/1/10 to 30/6/10. A comparison was made between the patients who completed the rehabilitation program and those who did not. The results were analyzed using the Microsoft Excel program.

Results

Demographic data revealed sixty male patients, majority of them were Chinese, aged between 31years to 40 years. Their diagnosis was Schizophrenia. 30 (50%) of the patients completed the 8 week inpatient rehab services of whom 62% were offered employment upon their discharge. These patients also experienced reductions in the readmission rates (76%), treatment default rates (72%) and hospital length of stay rates (79%). However in comparison to the other 30 (50%) patients who did not complete the rehabilitation program, there was only 40% reduction in readmission rates, 60% reduction in default treatment rates and only 38% reduction in hospital length of stay.

Conclusion

The positive clinical outcome of patients who completed the rehabilitation program and continued to receive case management support upon discharge is encouraging. The hospital will strongly encouraged all patients to undergo the rehabilitation program to ensure better quality of life and outcomes for them.

Poster 19. Supported independent living, community tenure and recovery process of people with schizophrenia. A cohort study.

Antonio Maone

Objective

Fifteen patients with schizophrenic and schizoaffective disorders were gradually transferred from a non-hospital residential facility to the community, in six independent permanent flats scattered across an urban context in the city of Rome, with flexible and individualized support, following an innovative recovery-oriented project involving patients, their relatives and social and community mental health services.

This 5-year follow-up is aimed to evaluate clinical and psychosocial outcome and to discuss some lessons learned from this initiative.

Method

Quantitative evaluation was conducted using the Brief Psychiatric Rating Scale, Global Assessment of Functioning, Quality of Life measures and qualitative semi-structured interviews.

Results

During the 5 years following relocation, only one patient was shortly admitted twice to a psychiatric in-patient clinic because of alcohol abuse. The residents maintained community tenure with significant improvement in quality of life, especially on the items regarding housing satisfaction. The availability of staff during the night has never been used, similarly incidents due to prejudices, intolerance and conflicts within condominium or neighbourhoods have never happened. Clinically, community residents don't have showed significant changes in psychiatric symptoms.

A careful cost analysis demonstrated that total expenditure for a single patient in the project for a year is similar to that needed for hospitalization in a psychiatric ward in General Hospital lasting 20 days.

Conclusion

The evidence from this experience confirms those described in the literature on the supported housing approach, which ultimately demonstrates that a wide rate of patients with persistent and serious mental illnesses can permanently live in independent accommodation, outwith institutions, and with flexible and individualized care. Independent living seems to be a key-factor in recovery process. But success of this type of approach seems to be closely connected to recovery-oriented practice, that has to be carefully and constantly monitored.

Poster 20. Hidden Talents: Celebrating the lived experience of staff within the NHS

Phil Morgan, Jackie Lawson

Introduction

The principles and philosophy of recovery apply not only to those who access the service but for staff that work within them (Shepherd et al 2010). Indeed Repper (2009) proposes that Recovery is "common to us all". With this in mind Dorset Community Health Services has commenced a unique project aimed at celebrating the lived experience and dual identities of staff. This project is seen as a central component to the wider cultural change in the NHS that is essential in order for NHS organisations to embed the principles of wellbeing and recovery.

Methods

The Hidden Talents group is in its infancy therefore no formal research has been conducted. Future research is planned using semi-structured interviews to obtain qualitative accounts of the group members to establish whether Hidden Talents has met its original aims to: Address stigma Share expertise around self-management Manage disclosure and its clinical application Provide peer support To provide guidelines for managers, human resources and occupational health in supporting staff with mental health problems.

Discussion

Initial feedback from this pilot project has been overwhelmingly positive however more formal research and evaluation is required. The Hidden Talents group has locally influenced the organisations response to staff with mental health problems, including developing guidelines for occupational health to support people with mental illness. A long-term goal is to also establish whether projects such as Hidden Talents improve staffs experience of working for the NHS organisation including their sense of value.

Poster 21. Expert Mentoring: The use of people to coach and mentor psychiatrists- A Pilot Project

Phil Morgan

Introduction

The coalition government promises to improve the experiences and choices of people who access Mental Health Services, central to this is "no decision about me without me."

An innovative project has commenced within Dorset whereby people with lived experience of mental health problems are coaching and mentoring psychiatrists in recovery orientated practice.

Method

This project is currently in the development phase a coaching manual is under development and being piloted. The pilot is being evaluated through the analysis of reflective accounts of the psychiatrist and mentor and through a case note audit.

Results

The initial indications from the pilot are that this has been a beneficial experience for both the psychiatrist and the mentor.

Discussion

Once the manual has developed from draft form, it is anticipated this pilot will lead into a larger research project. This project will evaluate the impact of this coaching style on the psychiatrists and people who access the service. This study will take place using a qualitative approach exploring both the psychiatrist and the person accessing the services' experience.

Poster 22. Empowerment and Schizophrenia: The experience of the Acolhimento Group at Programa de Esquizofrenia (PROESQ), Federal University of São Paulo (UNIFESP)

Fernanda Pimentel, José Alberto Orsi, Anna Miranda, Cecília Cruz Villares

Introduction

The Acolhimento Group for people with schizophrenia was established in 2005 through a partnership between the PROESQ and the Brazilian Schizophrenia Association (ABRE). It is an open group, not only for people in treatment at PROESQ but also for those who treat in other departments of health network. It happens once a week with an one hour duration. It is a potential opportunity for exchanges and discussions, where from their own experience and listening to other's experience, the patients can discuss issues relating to the experience of illness and its consequences in everyday life.

Methods

The coordination of the group is divided by two occupational therapists in partnership with two individuals with schizophrenia who assume a role as facilitators in discussions. The facilitators are there to make easier the communication and assist the group in meeting its objectives, and to promote the exchanges occur from the experiences of participants and not from the responses of the coordinators.

Results

This action promotes the validation of the place of authority that the person itself has from his experience, making the protagonist and a multiplier of such an initiative. The group take as principle the collaborative dialogue and the themes to be discussed are spontaneously brought by participants. Currently the group has averaged 20 participants.

Discussion

The Acolhimento Group contributes significantly to reduce the suffering of patients with schizophrenia, making it possible for better understanding of their disease and all that entails. In addition, through support, effective participation and collective construction of knowledge, raises up in participants a sense of belonging and helps to build a realistic hope towards life. It becomes possible to search by desires, interests and projects that may exist beyond the disease, providing the space for diversity and uniqueness.

Poster 23. Attention and memory training in stable schizophrenic patients: a double-blind, randomized, controlled trial using simples resources

Livia Pontes, Martins, Camila Bertini and Napolitano, Isabel Cristinacheck names

Background

Reports on cognitive training for schizophrenia have not been always uniformly positive, but various studies showed optimistic results, indicating its efficacy. We performed a double-blind, randomized,

placebo-controlled trial in order to investigate the efficacy of an attention and memory training program constructed using simple resources in a sample of stable Brazilian patients with schizophrenia.

Methods

57 outpatients with ages between 18 and 50 years and who fulfilled DSM-IV-R criteria for schizophrenia were invited to participate in this trial. Subjects were screened for the type of medication, neurological conditions, abuse or dependency of psychoactive substances, participation in a cognitive training program in the last six months, and were assessed for symptoms, intelligence quotient (IQ), attention, memory and quality of life. Seventeen subjects comprised the final sample! and were randomized in two groups: cognitive training or control. Interventions were composed of 20 sessions. Raters were blind to patients' condition, as well as patients, who were masked. Comparisons on baseline were made with Mann-Whitney test and chi-squared test. A nonparametric repeated measures ANOVA was used for comparisons between groups in different moments (pre and post intervention).

Results

Groups were matched at baseline. Final comparisons indicated that the cognitive training group showed a significant improvement in inhibitory control in comparison to the control group and a significant improvement in alternating attention over time. Both groups showed improvements in symptoms (positive symptoms and general psychopathology), information processing, selective attention, executive function and long-term visual memory. Improvements were found in the control group in long-term verbal memory and concentration in comparison to the experimental group. No differences were found in the memory functional assessment or quality of life.

Conclusion

Cognitive training in schizophrenia can be constructed using simple resources, which contributes to enhance cost-efficacy in the health system, and may improve cognitive functioning.

Poster 24. When Knowledge & Experience Meet

Tamar Sadan Lachs

Enosh, the non-profit Israeli Mental Health Association, was founded 33 years ago in order to promote the welfare and rights of people dealing with psychiatric disabilities. Enosh aims to improve the quality of life of these people by facilitating their productive and active integration into the community.

Enosh provides full and comprehensive solutions for rehabilitation within the community nation wide. These centres provide services to some 4,500 people dealing with psychiatric disabilities including supportive housing, hostels, vocational rehabilitation, occupational training and workshops, social rehabilitation, and family counselling and support.

After over 30 years of widespread professional activity, it became clear that there is a real need for a supervision network to accompany the rehabilitation staff during their professional development. Enosh decided that the supervision network would consist of professionals in various fields. At the first stage, we mapped these fields and chose the leading professionals. They were marked as top talents and assembled as an elite professional group. This group underwent training to become supervisors, which included receiving knowledge and skills in rehabilitation training as well as up-to-date theoretical rehabilitation information. Now it seemed that they were ready to start.

The hope was that the knowledge and experience of this group would be transferred to the rehabilitation professionals in the field and would sustain the entire rehabilitation system. In fact, a year into the supervisors' work, it became apparent that our assumption that an excellent rehabilitation professional would also be an excellent supervisor – was incorrect. Many of the supervisors faced difficulties being accepted and were still seen as colleagues rather than as a professional authority. Other difficulties stemmed from their lack of leadership skills and their struggle to detach themselves from the jobs in the field. Knowledge and experience, it was discovered, are insufficient to create a supervision network.

Poster 25. Participation in day centres for people with psychiatric disabilities: Reflections on occupational engagement.

Carina Tjornstrand, Ulrika Bejerholm, Mona Eklund

Introduction

People with psychiatric disabilities (PD) may experience many losses in their everyday life due to their illness and to stigmatization. Participation in community based day centre occupations may potentially provide experiences that make up for some of those losses. The aim of this study was to gain knowledge about the visitor's reflections on their occupational engagement in community day centres.

Method

Six day centres from four municipalities in the southern part of Sweden took part in the study. A total of eighty-eight persons participated. A time-use diary that covered the informants' most recent day at the day centre was completed. The transcribed data were analysed using thematic content analysis.

Result

The result indicated a main theme, being part of the spirit of togetherness and getting empowered. The sub-themes that emerged were termed: being socially included through participation in occupations, emotional reactions to variation and change, mastering challenges and learning something new, having balance and structure – or not – in daily life and getting motivated through contributing and being entrusted with responsibility.

Discussion

The day centres offered a way to break isolation, passivity and lack of routines and challenged their visitors to be more active and social in their daily life. The potential of community day centres to be a more recovery-based service and offer empowering occupations for people with PD can be discussed in relation to the findings. Moreover, further improvements within these services can be made to counteract occupational alienation and enhance the use of individually chosen occupations that empower the participants and help them reach important goals.

Poster 26. Solution Focused Coaching for Recovery

Tine Van Bortel

Introduction

Solution Focused Brief Therapy Coaching is a short, non-evasive verbal intervention focusing on the present and preferred future (rather than 'getting stuck' in / paralysed by analysing the past) by looking at the clients' strengths and setting small manageable goals. This intervention is characterised by 'non-labelling' of diagnostic categories which significantly reduces stigma and discrimination attached to (early) psychiatric labelling. A typical SF intervention takes normally less long than a CBT intervention with some clients only needing one or two talks.

Solution Focused Practice and Coaching is easy to learn by many and easily applicable by non-clinical practitioners. Therefore, it can easily be introduced in the community in order to alleviate the NHS.

Methods

I utilised qualitative interviewing and focus groups as well as drawing from my own practice as a qualified and registered Solution Focused Coach.

Results

Analysis is still being carried out however early indications show that, in our interviews, clients highlighted that they preferred Solution Focused Coaching by a non-clinical but trained coach rather than clinicians. Some of the reasons mentioned are the feeling of empowerment of taking control of their own lives but also the stigma attached to labelling and categorising clients, the stigma and discrimination attached to the mental health professionals (clinicians), the white coat syndrome of entering a formal clinicians' office, and more.

Discussion

Since this is still work in progress, discussion of the outcomes will follow in the next few months and at the conference.

Poster 27. Model of complex psychotherapeutic treatment of phobic disorders in conditions of Moscow Psychiatric Day Hospital

Llya Zakharov

Myths of agoraphobia – patient's myths (like inevitability of panic episodes), common mythology and myths created by specialists.

Reefs and traps of agoraphobia treatment – dilemma of prescription of stimulating vs sedative medications, especially in the very beginning of treatment course. Danger of paying too much attention to panic/phobic episodes and making them the primary target of psychotherapy, possibility of retraumatizing and strengthening the rigidity of syndrome due to excessive concentration on painful episodes. "Way home" psychotherapy, model of devaluation of syndrome and using "bright" periods as main target of psychotherapy. Dispelling the myths as one of the principal components of treatment. Using Anokhin's theory of functional systems in physiology to illustrate phobic episode and panic attack expectation and changing the aim point for recovery from phobia. Goal achievement as principle issue of "Way home" psychotherapy. Using existing patient's positive body and emotional

experience for achieving desirable status and reinforcing the results. Using metaphors in agoraphobia treatment. CBT, NLP elements and positive psychotherapy as psychotherapeutic instruments. Healing phobic disorders in conditions of day psychiatric hospital. Commonwealth of "3 psy's" – psychiatrist, psychologist and psychotherapist – in treatment of agoraphobia and panic attacks. Role of each of specialists and joint activity in creation of rehabilitation environment.

Change of psychotherapeutic tactic in coincidence with medication therapy and correction of pharmaceutical cure in accordance with psychotherapist activity.

Group of psychological rehabilitation as component of complex treatment. Using the positive experience of other patients as valuable instrument of recovery. Perspective of using "Way home" psychotherapy for other psychiatric diseases.

Events and resources initiated by the Section for Recovery at the Institute of Psychiatry

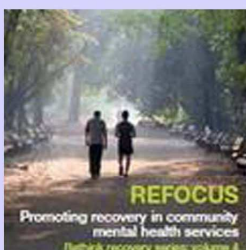
Website: researchintorecovery.com



SUMMER SCHOOL

Recovery: from research evidence to clinical practice and organisational transformation

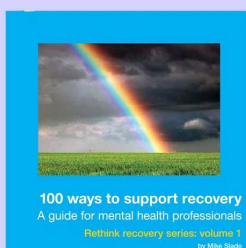
25-29 June 2012, London
kcl.ac.uk/hspr/summerschool



MANUAL

REFOCUS: Promoting recovery in community mental health services

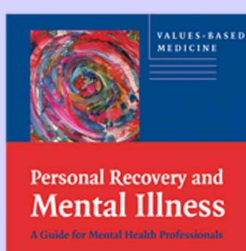
Free download: researchintorecovery.com/refocus



FREE GUIDE

100 Ways to support recovery

Free download: rethink.org/100ways



BOOK

Personal Recovery and mental illness

Information: goo.gl/A1Ruu



NETWORK

The Recovery Research Network

An England-wide network of people at the forefront of research into recovery. Info: researchintorecovery.com/rnn