Refocus on Recovery III

2014

2-3 June

International Conference

New Hunt's House, Guy's Hospital
London

Organised by: Section for Recovery at the Institute of Psychiatry, King's College London and Rethink Mental Illness.

In partnership with: ImROC (Implementing Recovery through Organisational Change).

Rethink Mental Illness.

ImROC
Implementing Recovery through Organisational Change

KING'S College LONDON

South London and Maudsley NHS
NHS Foundation Trust

KING'S HEALTH PARTNERS

Refocus on Recovery 2014 Outline timetable

All plenary talks will be held in the ReThink room

Monday 2 June 2014

0900	*Registration and refreshments*
1000	Start of conference day 1
1000 1010 1020 1030 1050	**Alison Mohammed** – Rethink Mental Illness **Lord Patel of Bradford** **John Larsen** – Outline of the day, Conversation Café **Terry Bowyer** – The journey of recovery **Ken Thompson** – Transforming services: Old baby, new bath? Old bath, new baby? New bath, new baby?
1110	*Refreshments, conversation café opens, poster viewing and voting*
1130	**Mike Slade** – Researching recovery
1150	Parallel session 1
1250	*Lunch, poster viewing and voting*
1400	**Mary Leamy** – The REFOCUS Study
1420	Parallel session 2
1520	*Refreshments, poster viewing and voting*
1540	**Sonia Johnson**– Alternatives to hospital
1600	Parallel session 3
1715	*End of conference day 1*
1715	*Social event: Amazing Race London Underground edition*

Tuesday 3 June 2014

0900	*Start of conference day 2*
0900 0910 0930	**Simon Bradstreet** – Outline of the day **Geoff Shepherd** – Organisational transformation **Liz Sayce** – Recovery, human rights and learning from the disability movement
0950	Parallel session 4
1050	*Refreshments, poster viewing and voting*
1110 1130	**Alessandro Svettini** – Changing services in Italy **Julie Repper** – Recovery Colleges, Co-production and Lessons Learnt
1150	Parallel session 5
1250	*Lunch, poster viewing and voting*
1400 1420 1440	**John Larsen** – Crisis Houses: an alternative approach to recovery **Graham Thornicroft** – The latest evidence on how to reduce stigma **Lindsay Oades** – From recovery to wellbeing
1500	*Refreshments, poster viewing and voting*
1520 1550 1620	**Samson Tse** – Messages of hope balloon release Debate – 'Recovery is now a meaningless term' For: **Nick Manning**, **Jan Wallcraft** Against: **Tom Craig**, **Phil Morgan** **Mike Slade** – Closing words/People's Choice Poster Award winner
1630	*End of conference*

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Welcome...

To the Refocus on Recovery 2014 conference. 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: System transformation

What approaches are used within mental health systems to support recovery? Specific interventions might include Recovery Colleges, peer working, personalisation and strengths approaches, as well as national initiatives such as ImROC to support organisational transformation. What new technologies are emerging? How can both front-line interventions and within-system culture be transformed?

Theme 2: Relationships that support recovery

How can the recovery resource of existing and new relationships be better harnessed? Does a recovery orientation change the construction of 'professionalism'? What are the active ingredients of peer relationships? How do family and friends understand 'recovery', and how do they support it? Can inclusive communities be created? How can the search for spiritual meaning be supported by others? Do coaching or co-production have a contribution?

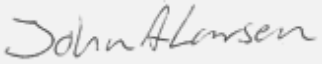
Theme 3: Recovery in crisis

What do people need in a crisis? How can crisis-oriented services promote hope and post-traumatic growth? Do we need new service models, such as recovery houses? Critical perspectives are also encouraged in this theme, such as threats posed by recovery rhetoric (e.g. will this be a cover for service cuts?), and concerns that recovery means employment. On close examination, what problems emerge with the recovery movement?

Theme 4: Keeping well in daily life

How can individuals live a life beyond illness? How to support wellbeing when having ongoing mental health problems? What well-being research does or does not apply to people experiencing mental health problems? What does recovery have to offer for citizenship, empowerment, and emancipatory and identity politics? Can lived experience be used to address stigma, and is there a role for mental health workers to be social activists?

Warm regards



Mike Slade — John Larsen

Institute of Psychiatry — Rethink Mental Illness.

Acknowledgements

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

- South London and Maudsley NHS Foundation Trust
- Rethink Mental Illness.
- ImROC

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.

Scientific Advisory Board

Mike Slade (Chair)
Tom Craig
Helen Gilburt
John Larsen
Angela Sweeney
Geoff Shepherd
Genevieve Wallace

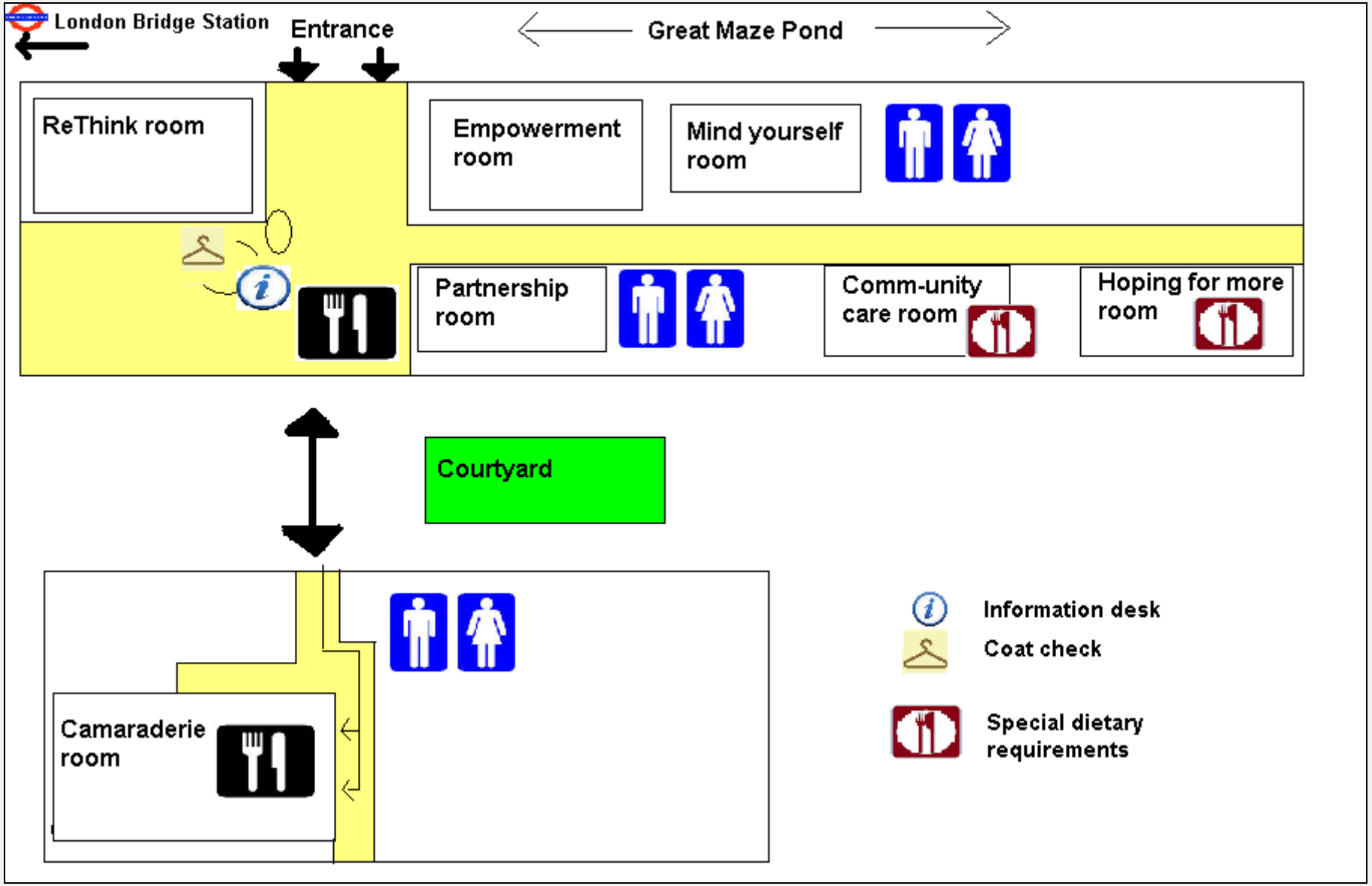
Local Organising Committee

Rebecca Leslie (Chair)
Mike Slade
Julie Smith
Ben Fortune
Kai Sabas

Additional information

- Helpers will be wearing white Refocus shirts.
- Please wear your name badge on the premises at all times.
- You are welcome to leave any luggage in the cloakroom, however the Local Organising Committee cannot accept responsibility for any items lost or mislaid on the premises.
- Please ensure your mobile phones are on silent during all sessions.
- This is a non-smoking venue.
- We hope you enjoy the conference!

Venue Map


London Bridge Station
Entrance
Great Maze Pond
ReThink room
Empowerment room
Mind yourself room
Partnership room
Comm-unity care room
Hoping for more room
Courtyard
Camaraderie room
Information desk
Coat check
Special dietary requirements

Timetable

Monday 2nd June 2014		
9.00-10am	***Registration and refreshments (New Hunts House foyer)*** ***Poster set up (Camaraderie room)*** ***Quiet space available in the MindYourself room all day***	
10am **ReThink room** John Larsen	**10.00am**	**Alison Mohammed** (Rethink Mental Illness) - Welcome
	10.10am	**Lord Patel of Bradford** - Welcome
	10.20am	**John Larsen –** Welcome/Outline of day, Conversation café
	10.30am	**Terry Bowyer -** The journey of recovery
	10.50am	**Ken Thompson -** Transforming services: old baby, new bath? old bath, new baby? new bath, new baby?
11.10am	***Refreshment break (foyer and Camaraderie room)*** ***Poster viewing and voting opens for the 'People's Choice Poster Award' (Camaraderie room)*** ***Conversation Café opens (Partnership room) available to drop in anytime throughout the day***	
11.30am **ReThink room** Terry Bowyer	**Mike Slade -** Researching recovery	

11.50pm	**Parallel Session 1**			
	Session 1.1 **Venue: ReThink room** Theme: System transformation Chair: Anne Cooke	**Session 1.2** **Venue: Empowerment room** Theme: Relationships that support recovery Chair: Bernd Puschner CEDAR symposium	**Session 1.3** **Venue: Comm-unity care room** Theme: System transformation Chair: Glenn Roberts	**Session 1.4** **Venue: Hoping for more room** Theme: Keeping well in daily life Chair: JH Venter
	Judith de Lang – Mental illness or complex trauma: treatment or counselling?	**Jana Konrad** – Content of clinical decisions and outcome in a European multicentre study of people with severe mental illness	**Justine Karpusheff** – Cultural activities for social isolation: how far does taking part generate social capital?	**Maggie Harmon** – Living your truth
	Mary O'Hagan – Imagining a world without coercive mental health legislation	**Malene Bording** – Involvement in clinical decision making across professions: a six country European study	**Galit Halperin** – Community recovery: a key concept for social integration of people with mental illness	**Shane Powell** – Living with Psychosis: a Peer Specialist-and-clinician delivered programme for Recovery in Psychosis
	Christien Muusse – Do it yourself!: consumer run homeless shelters in the Netherlands	**Aniko Egerhazi** – Context focused comparison of clinical decision making in European centres with regard to patient and clinician variables	**Sarah Pollock** – Challenging the 'expert professional-vulnerable client' dyad through socially inclusive practice	**Anneliese de Wet** – Hearing their voices: the lived experience of recovery from first-episode psychosis in schizophrenia in South Africa
	Vicky Stergiopoulos – Meaningful inclusion of consumers in research and service delivery	**Eleanor Clarke** – Empowerment and satisfaction: multinational study of routine clinical practice	**Vanessa Pinfold** – Connectedness and recovery: the role of practitioners in personal networks of people with severe mental illness?	**Miriam Goldberg** – The transition from patient to thera-patient for social work students with psychiatric difficulties
	Anne Cooke – Challenging narratives about psychosis	**Sabine Loos** – Recovery and decision making involvement in people with severe mental illness from six countries: longitudinal observational study	**Glenn Roberts** – 'How can psychiatrists support personal recovery: re-visioning training and professional development'	**Emma Lamont** – Finally finding our voices: mental health nurses talk about their belief in recovery, overcoming stigma and building a positive sense of identity

12.50-2pm	***Lunch (foyer and Camaraderie room and special dietary requirements in Hoping for more room and Comm-unity care room) Poster viewing/voting for the 'People's Choice Poster Award'(Camaraderie room)***			
2pm **ReThink room** Lindsay Oades	**Mary Leamy** - The REFOCUS study			
2.20pm	**Parallel Session 2**			
	Session 2.1 **Venue: ReThink room** Theme: Relationships that support recovery Chair: Mary Leamy REFOCUS symposium	**Session 2.2** **Venue: Empowerment room** Theme: Relationships that support recovery Chair: Ruth Chandler	**Session 2.3** **Venue: Comm-unity care room** Theme: System transformation Chair: Helen Gilburt	**Session 2.4** **Venue: Hoping for more room** Theme: System transformation Chair: Stephanie Daley
	Mary Leamy – Overview of REFOCUS intervention	**Mary O'Hagan** – PeerZone – peer led workshops in mental health and addiction	**Triona McCaffrey** – Evaluating music therapy through art, song and words: a service user perspective	**Stephanie Daley** – Implementing recovery within older people's mental health services – What are the issues?
	Eleanor Clarke – Staff perspectives of the REFOCUS intervention	**Steve Gillard** – New peer worker roles in mental health services: modelling the mechanisms of change	**Nick Dent and Lyndsey Wall** – Using appreciative enquiry in developing recovery oriented practice	**Helen P Hamer** – Upholding the contract: supporting the citizenship status of people who use mental health services
	Genevieve Wallace – Service user experiences of the REFOCUS intervention	**Ruth Chandler** – Voicing caregivers experiences of recovery and wellbeing	**Simon Bradstreet** – SRI2: a national recovery improvement initiative	**Bridey Rudd** – Enabling transformation within a Scottish mental health charity
	Victoria Bird – A cluster randomised controlled trial of a recovery intervention for black individuals who use community mental health teams	**Sandy McNeil** – Changing relationships in family-centred care	**Louise Christie** – Results from implementation of SRI2: a national recovery improvement initiative	**Samantha Adkins** – Exploring student and trainer experiences of Dorset's Recovery Education Centre
	Julie Williams – Development and testing of INSPIRE measure	**Julia Pelle** – African and African-Caribbean carers experience of supporting recovery in relatives with psychosis	**Louise Christie** – Enhancing recovery in a voluntary sector mental health provider	**Anthony Stratford** – Challenges and rewards of a recovery college down under

3.20pm	***Refreshment break (foyer and Camaraderie room and special dietary requirements in Hoping for more room and Comm-unity care room)*** ***Poster viewing/voting for the 'People's Choice Poster Award' (Camaraderie room)***			
3.40pm **ReThink room** Chair: Ken Thompson	**Sonia Johnson -** Alternatives to hospital			
4pm	**Parallel Session 3**			
	Session 3.1 **Venue: ReThink room** Theme: Relationships that support recovery Chair: Anne Marwick Shared decision making symposium	**Session 3.2** **Venue: Empowerment room** Theme: System transformation Chair: Beate Schrank	**Session 3.3** **Venue: Comm-unity care room** Theme: Relationships that support recovery Chair: Sally Lawson	**Session 3.4** **Venue: Hoping for more room** Theme: Keeping well in daily life Chair: Genevieve Wallace
	Shulamit Ramon – Shared decision making in mental health services	**Soeren Frost** – Third wave of implementing a recovery orientated approach in the city of Aarhus – engaging users in the implementation process and in measuring personal outcomes	**Kamilla Hasager Jensen** – Evaluation of the mental health first aid training course in a Danish context	**Ian Porter** – Critical reflections on role of home in supporting recovery for people with severe mental illness
	Elina Baker – Implementing recovery-focused prescribing and medicines management in practice	**Kurt Kyed** – Involvement of service users in reformulating the value based foundation	**Glinnis Goldring** – Enabling recovery in a structured hope programme	**Elizabeth Huges** – Mental illness stigma and sexual health
	Sheena Mooney – The development and implementation of the "ShIMME" training intervention to promote shared decision-making in psychiatric medication management	**Jakob May** – Involvement of service users in homeless shelters	**Helle Stentoft Dalum** – Illness Management and Recovery (IMR): a randomized trial and a qualitative study to investigate effectiveness of the IMR program	**Bror Just Andersen** – Practice in the C-Flex team in Baerum

	Nicola Morant – A mixed-method evaluation of the "Shimme" training intervention to promote shared decision making in psychiatric medication management	**Runa Bjorn** – Screening of recovery indicators at an organizational level – do our service providers facilitate recovery?	**Jerry Tew** – Can personal budgets help to bring about a recovery 'mindset' in service users' relationships with practitioners?	**Oona Lassenius** – Being physically active: a bodily anchorage on the journey toward recovery
	Anne Markwick – Organisational change, recovery and shared decision making	**Malte Pihl** – Performance measurement and recovery orientation	**Lisa Korsbek** – Disruptive innovations – system transformation through decision aids	**Calgan Zeynep** – Pharmacists' role in personal recovery and wellbeing: what do the published studies say in PubMed
	Yaara Zisman-Ilani – From theory to practice: facilitating shared decision-making in psychiatric hospitals	**Chris Collins** – Social housing in mental health: impact of anti-social behaviour on service users	**Olga Shek** – Empowerment and user participation in post-soviet mental health services: reflections from the soviet past?	**Vicky Stergiopoulos** – Coping in context: experiences of homeless people with mental illness from racialized groups
5.15pm	***End of Day 1 scientific programme***			
5.15pm	***Social event – Amazing Race London Underground edition (New Hunts House foyer)*** ***A good local English pub is the George Inn, 77 Borough High Street, London SE1 1NH (Food/drinks not included)***			

Tuesday 3rd June 2014					
9am	***Quiet space available in the MindYourself room all day*** ***Poster viewing/voting for the 'People's Choice Poster Award' (Camaraderie room)***				
9.00am **ReThink room** Simon Bradstreet	**9.00am**	**Simon Bradstreet** – Welcome/outline of the day			
	9.10am	**Geoff Shepherd -** Organisational transformation			
	9.30am	**Liz Sayce -** Recovery, human rights and learning from the disability movement			
9.50am	**Parallel Session 4**				
	Session 4.1 **Venue: ReThink room** Theme: System transformation Chair: Bridget Hamilton Symposium: Shifting to recovery orientation together, across public sector mental health services	**Session 4.2** **Venue: Empowerment room** Theme: Relationships that support recovery Chair: Nicola Morant	**Session 4.3** **Venue: Partnership room** Theme: Relationships that support recovery Chair: Simon Riches	**Session 4.4** **Venue: Comm-unity care room** Theme: Keeping well in daily life Chair: Chris Griffiths	**Session 4.5** **Venue: Hoping for more room** CEDAR study meeting Chair: Bernd Puschner
	Bridget Hamilton – Recovery orientation in policy agenda	**Agnete Neidel** – Partnerships for inclusion and citizenship – community mapping: a way forward?	**Jessica Holley** – The impact of risk management practice upon the implementation of recovery-oriented care	**Cath Quinn** – Producing a booklet on talking therapies and ideas to help yourself	Open to CEDAR team only
	Bridget Hamilton – Recovery orientation in the strengths model in a clinical setting	**Martin Webber** – The connecting people intervention: findings of a quasi-experimental pilot study	**Yael Bankirer** – Undermining the narrow concept of motherhood: a consciousness-raising group therapy of women who are both mothers and coping with mental disability	**Helene Regle** – Could the French practice of "Institutional Psychotherapy" be recovery oriented?	

	Bridget Hamilton – Recovery orientation in consumer-led education & research	**Bernard Pachoud** – Why supported employment benefits from being a recovery-oriented practice	**Oona Lassenius** – Motivating to physical activity – a way of being, relating and understanding	**Chris Griffiths** – Recovery house 'sleep pack' initiative	
	Cath Roper – Recovery orientation in non-government support services				
	Sarah Pollock – Recovery orientation in clinical service management				
10.50am	***Refreshment break (foyer and Camaraderie room)*** ***Poster viewing/voting for the 'People's Choice Poster Award' (Camaraderie room)***				
11.10am **ReThink room** Geoff Shepherd	**11.10am**	**Alessandro Svettini -** Changing services in Italy			
	11.30am	**Julie Repper -** Recovery colleges, Co-production and Lessons Learnt			
11.50am	**Parallel Session 5**				
	Session 5.1 **Venue: ReThink room** SLAM Recovery College Launch Chair: Kirsty Giles / Gabrielle Richards	**Session 5.2** **Venue: Empowerment room** Theme: System transformation Chair: Clair Le Boutillier	**Session 5.3** **Venue: Partnership room** Theme: Keeping well in daily life Chair: Alison Beck	**Session 5.4** **Venue: Comm-unity care room** Theme: System transformation Chair: Nick Manning	**Session 5.5** **Venue: Hoping for more room** Theme: System transformation Chair: Phil Morgan
		Jackie Lawson – "Walking the walk": how NHS staff's own experience of trauma can shape recovery orientated culture	**Bridget Hamilton** – Transforming acute inpatient nursing practice – orienting to recovery	**Richard Byng** – Resource mobilising individualised recovery	**Trentham Furness** – Supporting recovery in acute adult in-patient mental health services

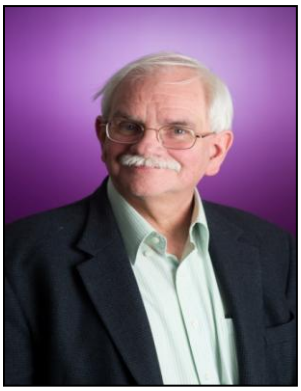
		Clair Le Boutillier – Staff perspectives on supporting recovery	**Bridget Hamilton** – Sharing co-production expertise: consumer involvement station	**Sanaz Riahi** – A recovery oriented approach in the prevention of restrain and seclusion in a Canadian mental health hospital	**Trentham Furness** – Becoming recovery-oriented at a secure adult in-patient mental health service
		Lone Hellstrom – Early supported employment for patients with anxiety or an affective disorder	**Beate Schrank** – Wellfocus positive psychotherapy group for people with psychosis: results of a pilot randomised controlled trial	**Ian Dawe** – Implementation of recovery rounds in the prevention of restraint and seclusion	**Nicola Wright** – Promoting recovery through knowledge sharing: a qualitative study of care transitions into and out of acute inpatient ward
		Bror Just Andersen – All inclusive – or not? ACT and FACT about practice, methods, and the effect-evaluation of C-Flex in Norway	**Simon Riches** – Therapist self-disclosure in positive psychotherapy for psychosis	**Philip Klassen** – Intimacy recovery: supporting patient intimacy in an inpatient mental health setting	**Mick McKeown** – Researching and developing recovery initiatives in a high secure hospital
		Monica Strand – eHealth and recovery – what are the potentials?	**Tamsin Brownell** – The wellfocus study: development of an intervention to increase well-being in people with psychosis	**Sarah Brand** – Engager 2: developing and evaluating a collaborative care intervention for prisoners with common mental health problems, near to and after release	**Myra Piat** – Moving from custodial housing to autonomous housing: a study on transformative change and recovery
12.50-2pm	***Lunch (foyer and Camaraderie room and special dietary requirements in Hoping for more room and Comm-unity care room) Poster viewing/voting for the 'People's Choice Poster Award' (Camaraderie room)***				
1.15-1.45pm	***Pause for Thought (MindYourself room)***				
2pm ReThink room Vanessa Pinfold	**2pm**	**John Larsen -** Crisis Houses: an alternative approach to recovery			

	2.20pm	**Graham Thornicroft -** The latest evidence on how to reduce stigma
	2.40pm	**Lindsay Oades -** From recovery to wellbeing
3pm	***Refreshment break (foyer and Camaraderie room)*** ***Last chance to vote for your favourite poster for the 'People's Choice Poster Award' (Camaraderie room)***	
3.20pm **ReThink room** Glenn Roberts	**3.20pm**	**Samson Tse –** Messages of hope balloon release/wellbeing event
	3.50pm	Debate: Recovery is now a meaningless term For: **Nick Manning, Jan Wallcraft** Against: **Tom Craig, Phil Morgan**
	4.20pm	**Mike Slade -** Closing words/Poster awards
4.30pm	***End of Conference***	

Our Keynote Speakers

Terry Bowyer is a Peer Specialist in mental health with lived experience of serious mental illness and recovery. He believes passionately in using and sharing his own perspective on the routes to wellbeing to aid people who use and work in mental health services. Since his involvement working began Terry has worked in research, governance, activism, fundraising, campaigns, and peer support. He regularly lectures at his local university on recovery and helped design and deliver peer-led wellbeing recovery sessions for people in crisis as well as a psychosis support course for people in the community. Terry will be speaking on 'The journey of recovery' 10.30am Monday 2nd June in the ReThink room.

Tom Craig is Professor of Social & Community Psychiatry at King's College, London Institute of Psychiatry, and the South London and Maudsley NHS Foundation Trust. He qualified in medicine at the University of the West Indies and trained in psychiatry in Nottingham UK. His clinical research activities focus on developing and evaluating community-based psychiatric services and the promotion of these at a National and International level. Tom will be taking part in the debate 'Recovery is now a meaningless term' 3.50pm on Tuesday 3rd June in the ReThink room.



Sonia Johnson is Professor of Social and Community Psychiatry at University College London. She is interested in evaluating complex psychosocial and team-level interventions for people with significant mental health problems, especially in acute care and in early intervention services for psychosis. Currently she is leading large scale studies on strategies to improve care in crisis resolution/home treatment teams, and on an intervention for reducing cannabis use among people with early psychosis. She is also involved in studies on social firms for mental health service users, offending against people with severe mental health problems, perinatal mental healthcare and involving service users in medication decisions in secondary mental health services. Sonia will be speaking about 'Alternatives to hotpital' 3.40pm Monday 2nd June, ReThink room.

John Larsen is the Head of Evaluation in the English mental health charity Rethink Mental Illness. He has a background as an anthropologist and has for more than 15 years undertaken research in mental health, working together with staff and people with personal experiences of mental illness. John has recently been working with the charity's Recovery and Crisis Houses to offer alternative services for people who are in mental health crisis and develop practice tools for recovery-oriented routine outcome data capture, examining the impact of the services. John will be speaking about 'Crisis Houses: an alternative approach to recovery' 2pm Tuesday 3rd June, ReThink room.

Mary Leamy is the Programme Co-ordinator on a 5 year 'REFOCUS' project which aims to develop a recovery focus in mental health services. On obtaining her PhD, she worked as a Senior Research Associate at Lancaster University on a study looking at housing decision making in older adults and then took a Senior Lecturer post in Psychology, at Teesside University, where she taught Applied Research Methods, and Social and Developmental psychology. She will be speaking about 'The REFOCUS study' 2pm Monday 2nd June, ReThink room.

Nick Manning has conducted research in the field of mental health since 1973. He has also worked extensively on issues of social change in Eastern Europe, including social movements, and on employment, poverty and health in Russia. Professor Manning has over 140 publications including 30 books or editions. Nick will be taking part in the debate 'Recovery is now a meaningless term' 3.50pm on Tuesday 3rd June in the ReThink room.

Alison Mohammed works for Rethink Mental Illness as Chief Operating Officer. She has responsibility for over 250 services, ranging from advocacy, supported housing, talking therapies, help-lines, to community services, crisis and recovery houses and carers' support. She is a sibling of someone with a severe and enduring mental illness, and as such is very committed to the idea of recovery and of hope, especially in these challenging times. The idea of recovery powers her work at Rethink Mental Illness – she wants us to try and support people to recover, feel better, get through, feel supported and not alone. Alison will be speaking about 'Recovery: here to stay' 10am Monday 2nd June, ReThink room.

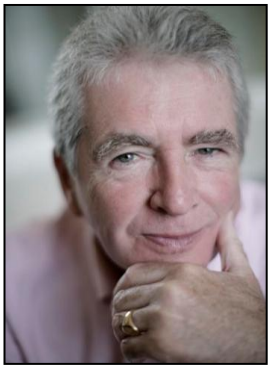
Phil Morgan serves as for the Dorset Well-being and recovery partnership and is committed to exploring how Recovery principles can shape our learning about ourselves, others and the organisations that we work within. Phil will be taking part in the debate 'Recovery is now a meaningless term' 3.50pm on Tuesday 3rd June in the ReThink room.

Lindsay Oades is the Director of the Australian Institute of Business Wellbeing at Sydney Business School, University of Wollongong, Australia. Lindsay is also on the scientific advisory board at the Institute of Coaching at Harvard University. Lindsay's work on stages of psychological recovery and the Collaborative Recovery Model (CRM) has been recognised internationally. Lindsay has published over 90 articles and book chapters related to wellbeing, recovery and coaching and is co-editor of the International Journal of Wellbeing. In 2013 he was awarded an Australian Government citation for outstanding contribution to student learning. Lindsay currently consults to the Australian and NSW Mental Health Commission on areas related to wellbeing. Lindsay's application of wellbeing ranges from individuals, mental health systems, to schools, workplaces and liveable cities. Lindsay will be speaking about 'From recovery to wellbeing' 2.40pm Tuesday 3rd June, ReThink room.

Lord Patel of Bradford is internationally renowned for his work with communities and social cohesion across a range of issues including mental health, drug and alcohol use, crime and regeneration. Lord Patel is also appointed shadow Minister for Communities in the House of Lords.
Lord Patel will be welcoming delegates to the conference 10am Monday 2nd June, ReThink room.

Julie Repper is Recovery Lead at Nottinghamshire Healthcare Trust and Associate Professor at University of Nottingham. As a nurse, lecturer, researcher, manager, practitioner and service user she has been developing her own understanding of Recovery for 20 years and supporting the development of Recovery focused services for 10 years. Julie has written widely on the subject, undertaken collaborative research and has led the provision of training in peer support and an MSc in Recovery at Nottingham University. Julie will be speaking about 'Recovery Colleges, Coproduction and Lessons Learnt' 11.30am Tuesday 3rd June, ReThink room.

Liz Sayce is Chief Executive of Disability Rights UK, the UK's leading pan-disability organisation. She is a Commissioner at the UK Commission for Employment and Skills and has recently led an Independent Review into disability employment programmes. With personal experience and knowledge of mental health issues, she has published widely on mental health, disability and social inclusion, including From Psychiatric Patient to Citizen (Macmillan-Palgrave 2000). Liz was awarded an OBE in 2008 in recognition of services to disabled people. Liz will be speaking about 'Recovery, human rights and learning from the disability movement' 9.30am Tuesday 3rd June, ReThink room.

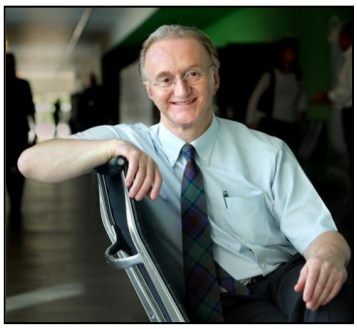


Geoff Shepherd trained originally as a clinical psychologist. He has worked most of his professional career in mental health services in the NHS as a practitioner, manager and researcher, working mainly with people who have long-term and complex conditions. He has also worked outside the NHS, from 1994 -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 in reach teams in local prisons and undertakes other consultancy work. Geoff will be speaking about 'Organisational transformation' 9.10am Tuesday 3rd June, ReThink room.

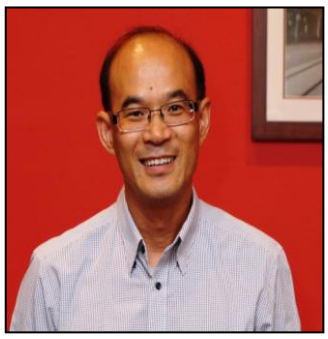
Mike Slade is Professor of Health Services Research at the Institute of Psychiatry, King's College London, and Consultant Clinical Psychologist in South London. His main research interests are recovery-focused and outcome-focused mental health services, user involvement in and influence on mental health 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. Mike will be speaking about 'Researching recovery' 11.30am Monday 2nd June, ReThink room.

Alessandro Svettini is an Italian psychiatrist and psychotherapist currently working as Director of the Service for Early Psychiatric Rehabilitation and Recovery Gelmini in Bolzano (Italy). Alessandro's main professional activity is in the field of psychiatric rehabilitation for more than 15 years, his main interests as a researcher are in the field of quantitative and qualitative research on recovery from psychiatric disabilities, in particular regarding fostering and hindering factors of recovery. Dr. Svettini has a direct experience of a parent with psychiatric illness and, as a family member, is active in family organisations at local as well as at European level, being member of EUFAMI board of directors. Alessandro will be speaking about 'Changing services in Italy' 11.10am Tuesday 3rd June, ReThink room.

Kenneth Thompson is a Public Service Psychiatrist and Clinical Associate Professor of Psychiatry and Public Health at the University of Pittsburgh. He has focused his career on improving psychiatric services, primary care and community/population health with a particular emphasis on achieving health equity. Ken has provided expert psychiatric consultation to public policy formation and implementation. From 2010 till 2013 he was the Chief Medical Officer for the Recovery Innovations, a multi-state and internationally known provider of peer and professional recovery oriented crisis and outpatient services. He remains a consultant to Recovery Innovations. Ken speaks and consults internationally on the transformation of psychiatry and psychiatric services, focusing on putting recovery into practice, integrating primary care and behavioural health, achieving health equity and population health and promoting public service. Kenneth will be speaking about 'Transforming services: old baby, new bath? old bath, new baby? new bath, new baby?' 10.50am Monday 2nd June, ReThink room.



Graham Thornicroft's areas of interest and research include health service research, implementation and improvement science, mental health needs assessment, development of outcome scales, service user involvement in research, cost-effectiveness evaluation of health interventions, stigma and discrimination, and mental health services in low income countries. Graham will be speaking about 'The latest evidence on how to reduce stigma' 2.20pm Tuesday 3rd June, ReThink room.



Samson Tse is an Associate Professor in mental health and Director of the Master of Social Science in Counselling Program at the Department of Social Work and Social Administration, The University of Hong Kong. Prior to his relocation to Hong Kong in 2009, Samson worked in New Zealand for 20 years. He has had a long standing interest in supporting persons - individually and collectively - affected by persistent psychiatric disability such as bipolar disorders by using the recovery approach and strengths model of case management. He has also been involved in several e-based mental health promotion projects in Hong Kong and New Zealand. Samson will be leading the 'Messages of hope balloon release' on 3.20pm Tuesday 3rd June.

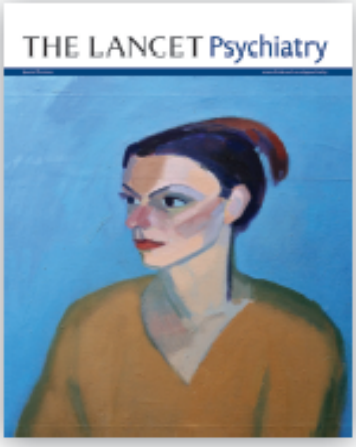
Jan Wallcraft is a freelance researcher with personal experience as a mental health service user and activist. She has a PhD from South Bank University London examining narratives of first experiences of breakdown. She is a researcher at Wolverhampton University and a Fellow of Birmingham and Hertfordshire Universities. She has written several articles and book chapters on recovery but has become concerned about the ways in which the ideals of recovery are being transmuted by commissioners to suit a different agenda from that of service users who originated the concept. Jan will be taking part in the debate 'Recovery is now a meaningless term' 3.50pm on Tuesday 3rd June in the ReThink room.

A fresh start for psychiatry

Psychiatry is at a turning point in its history. Cutting edge biomedical research, new concepts in service delivery, and increased awareness of the interaction between physical and mental health are transforming the specialty.

Mental health practitioners need a source of information that is authoritative, innovative, and pragmatic. *The Lancet Psychiatry* is that source, and will be launching this June.

To learn more about the scope and aims of the journal visit www.thelancet.com/psychiatry, or submit a manuscript at http://ees.elsevier.com/thelancetpsych.



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Other activities

As well as the scientific programme, Refocus on Recovery events are enjoyable and contribute to the development of an accessible and inclusive recovery community. We have a number of events taking place over the course of the conference:

The Different Voices' Conversation Café
Monday 2nd June between 11.10am and 5pm in the Partnership room
This is a simple way of bringing people together to start conversations that will lead to a better understanding of mental health issues and hopefully reduce stigma. The Conversation Cafe is an interactive space in which people with lived experience of mental health problems can share - over tea and cake and in a comfortable and relaxed atmosphere - their stories and reflections with people who don't have that experience. People can freely ask questions and have meaningful dialogues about mental health with the Conversation Cafe volunteers. The Different Voices' Conversation Cafe is run by The Advocacy Project, a charitable organisation that helps service users to speak up and get their voices heard, upholds and protects service users' rights, supports service users to be involved in their own care and treatment, supports service user involvement in the planning and delivery of services, and promotes quality in services.

People's choice poster award
Voting open between 10am Monday 2nd June and 3.20pm Tuesday 3rd June in the Cammaraderie room
For the poster winner at this conference YOU will be voting for the best poster. First place gets £100 amazon voucher and runner up gets £50 amazon voucher! So make sure you vote for your favourite poster. Voting slips will be in your delegate pack and to post your vote look for the Royal Post Mail box in the poster room (Camaraderie room). Criteria for judging a good poster is based on scientific value, clarity of presentation and visual impact.

Quiet room
Will be available from 10am Monday 2nd June through to 4.30pm Tuesday 3rd June in the MindYourself room
The quiet room is available for anyone who needs a place to get away from things for a while. The venue has a nice outdoor area available, but if you want a quiet room away from people then the MindYourself room is available throughout the conference.

Pause for thought session
Tuesday 1.15pm to 1.45pm in the MindYourself room
There will be an optional facilitated session to support those delegates who want to discuss and process their experiences at the conference. The session will be facilitated by people with professional and lived experience.

SLAM Recovery college launch
Tuesday 3rd June 11.50am in the ReThink room
The SLaM Recovery College will be formally launched in parallel session 5.1 in the ReThink room.

Messages of hope balloon release
Tuesday 3rd June 3.20pm in the ReThink room
This year at Refocus on Recovery 2014 we will be releasing messages of hope to the world attached to balloons! We hope our messages will reach people on the streets of London and beyond. Delegates will be given the opportunity to write a message of hope and we will all release our messages together. So start thinking now – what would you tell the world if you had the chance to change someone's day and inspire hope?

Amazing Race London Underground edition
Monday 2nd June 5.15pm starting from New Hunts House foyer area
On the evening of 2 June, there will be a free Amazing Race London Underground edition for teams to take part in, ending up at a traditional English pub (drinks not included unfortunately). The race is a set of challenges which involve a variety London trademark sights and stations to showcase what the London Underground is all about. The race is optional and is open to all delegates who wish to participate. There will be prizes for first place and runner up, last place and spot prizes.

Essential equipment:

- Photo taking device (make sure it is fully charged!)
- London underground travel card for zone 1 or oyster card

All challenges require photographic evidence to receive points. You have two hours to complete the challenges and must reach the final destination by 7.30pm or you will be deducted penalty points (a point deducted for each minute late). Take water (the tube network will be hot) and suitable footwear is recommended.

You must have two or more people in a team (no maximum) but all photos must be on the one device for a team. At the event you will be allocated a team unless you already have a team arranged. The race will start in the New Hunts House foyer at 5.15pm, so please ensure you are in the Foyer to get into teams and receive your challenges!

ORAL PRESENTATIONS

Keynote speakers (ReThink room)

Monday 2nd June

Alison Mohammed **Recovery: here to stay 10am**
Although 'recovery' is no longer the latest new concept driving policy and service improvement, it has lost none of its original critical relevance. At Rethink Mental Illness we still hear repeatedly from people using mental health services and their relatives about poor experiences, where people are simply not being listened to. But we also hear from people who have experienced real support and engagement from dedicated staff, and how this has helped them to find hope, build on strengths and turn their lives around. The journey to transform mental health services has only just started – recovery is here to stay.

Lord Patel of Bradford **Wellbeing matters 10.10am**
We know that poor mental wellbeing can have an impact on recovery – it can have a negative impact on our physical health, affect our work, our relationships and our families. Good mental wellbeing can help us achieve recovery and our goals in life. The policy challenges around mental health have been outlined in the current mental health strategy No Health Without Mental Health, but what steps have the Government taken to make this a reality and to ensure good mental wellbeing, and will we be able to deal with future demands?

Terry Bowyer **The journey of recovery 10.30am**
In my presentation I will attempt to map out the whole mental health experience from extreme illness to wellness. I will touch on how it feels to breakdown and experience all the scary symptoms that happen to you when you are unwell. I will cover the whole recovery journey and describe all the things that have contributed to my route to wellbeing thus far. I see recovery as a learning experience which enables the person to take control of their life, get back into the world, and flourish once again. Hopefully my talk will give people hope that wellness, even from the ravages of Schizophrenia, is achievable and should be basic requirement of our mental health system.

Ken Thompson
Transforming services: old baby, new bath? old bath, new baby? new bath, new baby? 10.50am

Putting recovery into psychiatric practice has been a significant challenge. Its clear that the process of recovery belongs to the person who's recovery it is. It is entirely personal. But it can be difficult and hard work, and a helping hand and a variety of tools can be useful. Traditional psychiatric services have long been ambivalent about personal recovery and the exercise of personal agency by people "being cared for". While the idealistically stated goal of psychiatric care has been to help people return to their full capacities and decision making abilities, in practice many approaches to providing care have substituted the care providers desires and choices for those of the person in need of help- often to the point of coercion. What, if anything, can be salvaged from past practice as we move to develop services the support, rather then stifle, personal recovery? What needs to be discarded? And what needs to be created for the first time? How can recovery oriented practitioners deal the thorny issues of danger and coercion? In the United States, the Recovery to Practice initiative, sponsored by the Substance Abuse and Mental Health Administration (SAMHSA) has been focused on these questions. The evolving American approach will be described and compared to similar efforts in the UK to see where the path forward may lie on both sides of the Atlantic.

Mike Slade
Researching recovery 11.30am

Our understanding of recovery is maturing. Part of this process involves evaluating the extent to which proposed approaches to supporting recovery deliver on their promise. This talk will provide a current appraisal of scientific knowledge in relation to pro-recovery interventions, including peer support, lived experience and initiatives to promote citizenship. Interventions which have the strongest empirical evidence will be identified, and the most pressing knowledge gaps will be highlighted.

Mary Leamy
The REFOCUS study 2pm

The REFOCUS study, which aimed to increase the recovery-focus of mental health services in England, is coming to an end. This talk will bring together some of the key findings emerging from this programme and discuss the impact of the work to date.

Sonia Johnson
Alternatives to hospital 3.40pm

Alternatives to acute admission have a long history, are often favoured by service users, and also have potential to prevent high expenditure on hospital inpatient stays whose therapeutic

value is unclear. In this presentation, I will describe the main available alternatives to admission, which are crisis resolution and home treatment teams, crisis houses and acute day services. I will summarise the current state of the evidence for them. I will also discuss the factors that facilitate and impede successful implementation of these models to achieve good outcomes and acceptability to service users and carers.

Tuesday 3rd June

Geoff Shepherd
Organisational transformation 9.10am

This talk will describe the process and outcomes of the 'Implementing Recovery through Organisational Change' (ImROC) programme. It will be argued that the key driver for organisations wishing to support recovery lies in locally owned initiatives, based on the 'co-production' of new services by mental health professionals and people with 'lived experience' of mental health problems, their families and other carers. This is most effectively facilitated through local managers who have vision and commitment and networks of mutual support. In the present climate new money would be desirable, but is unlikely. Service developments to support recovery therefore have to provide strong Business Cases which demonstrate both their effectiveness and their potential to save money. This kind of evidence is now beginning to emerge, but is understandably scarce. It constitutes one of the most important areas for future research in this field.

Liz Sayce
Recovery, human rights and learning from the disability movement 9.30am

Recovery requires tangible opportunities to lead the life you choose and participate in everything from work to dating and family life. The wider disability movement tackles this by adjusting the external world – the attitudes and behaviours of employers and service providers, the barriers in the built and communications environments. In 2014-15 the UN Committee on the Rights of Persons with Disabilities will examine the UK. Liz will talk about the opportunities this presents to open up opportunities for full citizenship participation for people with mental health problems. Removing barriers in the social world is necessary to recovery.

Alessandro Svettini
Changing services in Italy 11.10am

"Recovery" in Italy is today perhaps still between being "the new kid on the block" and the new buzzword in psychiatry; nevertheless, in these last couple of years, some first concrete recovery-oriented initiatives have grounded their roots inside and outside Italian mental health services. This presentation will describe this process of change illustrating four levels where interventions are conducted: the development and diffusion of recovery-oriented assessment tools, the scientific research on qualitative and quantitative aspects of recovery from psychiatric disability, service users as well as professional workforce education and

training, the use of social networks and mass media to increase public awareness of recovery as a possible and attainable condition.

Julie Repper
Recovery Colleges, Coproduction and Lessons Learnt 11.30am

In the past four years at least 18 Recovery Colleges have opened in England and services in other parts of the world have drawn on our learning to develop educational units (for example Italy, Japan, Republic of Ireland and Australia). Recovery Colleges offer courses (all co-developed, delivered and attended by both professionals and service users/family members) in all aspects of Recovery (from living with various conditions, to managing aspects of life, to accessing work and education). We have been running a Recovery College in Nottingham for the past four years. Around 1500 students attend the 100 courses running in the college every term. Students evaluate their learning extremely positively with 85% rating courses as very good or excellent. They most value meeting other people with similar experiences to their own, and they consider the most important learning being from other students who have found ways of coping. Social networks improve significantly through attendance of the college and engagement in social activities also increases. This paper will describe our experiences in Nottingham, what we have learnt, how we have developed 9 core principles that guide us and hold the integrity of our College, and how we maintain co-production and monitor quality in all of our activities.

John Larsen
Crisis Houses: an alternative approach to recovery 2pm

Mental health service users have long been requesting better care and support when they are in crisis. Although psychiatric hospital wards can provide a safe place for those in acute distress, it is rarely experienced as an optimal environment for recovery. In response, the English mental health charity Rethink Mental Illness has developed alternative services for people in crisis, including crisis or recovery houses and an innovative 12-week follow-up service to help people continue their recovery and (re-)integration into the community. Findings from outcome and process evaluation studies are presented.

Graham Thornicroft
The latest evidence on how to reduce stigma 2.20pm

Stigma and discrimination against people with mental illness are common and severe wherever they have been studied. One surprising aspect of this is that many consumers report that they feel discriminated against by health and social care staff, even though these are precisely the staff who are trained and experienced in offer assistance to people with mental illnesses. Furthermore, the ‘social contact’ hypothesis suggests that those with more contact with people with a diagnosis of mental illness will have more favourable and less stigmatising views. This paper will review evidence about discrimination and evidence of what is effective (at the local and national levels) to reduce stigma and discrimination.

Lindsay Oades
From recovery to wellbeing 2.40pm

Whilst many people are positive towards mental health recovery as a policy direction, debates continue as to whether it is best conceptualised as a process, an outcome, an orientation, a lived experience, a guiding principle, ad absurdum. In this presentation the debate about mental health recovery will be likened to a Zen Koan, for which there is no simple or western logical answer, however deeper insights may be gained from pondering such questions. It will be argued that mental health recovery is a necessary "transitional discourse" to assist with the reconceptualization of mental health and mental health service provision. In parallel with the debates about mental health recovery, there is an emergence of a science of wellbeing to complement existing approaches to treatment of disorder and prevention of illness. The convergence of the mental health recovery movement and the science of wellbeing has significant implications for the understanding of mental health, the role of mental health services and attributions as to who is responsible for a positive mental health outcome.

Parallel Session 1 - 11.50am Monday 2nd June

Session 1.1: System transformation (ReThink room)

Judith de Lang
Mental illness or complex trauma: treatment or counselling?

Individuals often present to health services in distress seeking a mental health diagnosis or with a diagnosis already confirmed. If the only service available to acknowledge mental health distress is a mental health service, the lens through which the distress is viewed is limited.
Methods
If individuals undergo a brief initial assessment, and then are provided with options for further response, how would demand on services shift and what would be the potential for recovery? The Adverse Childhood Experiences (ACE) study used a comprehensive questionnaire in 1995 and is continuing to track and disseminate results from over 17,000 participants. The study is currently being replicated in several countries including Canada, China, Jordan, Norway, the Philippines and the United Kingdom. From the initial questionnaire, a brief tool of ten questions has been developed which calculates a person’s ACE score.
Results
Results of the study show significant health, neurological and social impacts which are dose-dependent and can lead to a myriad of issues affecting the lives of individuals and their families. *Discussion*
What if all individuals presenting for mental health services were initially presented with the ACE score calculator and briefly informed about its purpose and findings? What if they were then informed of various options on how to proceed to the support they require? When the ACE findings become common understanding, what potential impact does this have on areas of policy including health, education, corrections, drug and alcohol, obesity, housing, employment, welfare provision and family services?

Mary O'Hagan
Imagining a world without coercive mental health legislation

There is some debate about whether compulsory treatment is compatible with a recovery approach in mental health. This talk traverses the issues and argues that special mental health legislation is discriminatory - people with a diagnosis of mental illness should be subjected to the same threshold for coercion as other people in our health and justice systems. The speaker then plays an imaginary radio interview in 2042 where the she is being interviewed for a programme that describes a recent overhaul in legislation where people with mental distress have the same rights as other citizens in the area of consent to treatment - the Mental Health Act and the insanity defence have been replaced with generic 'treatment without consent' legislation in health, open door services for suicidal people and humane recovery focused approaches for people with mental distress in the criminal justice system. If these changes happened, coercion in mental health would be drastically reduced and a recovery based service system would become a reality rather than a dream.

Christien Muusse, Michiel Lochtenberg
Do it yourself!: consumer run homeless shelters in the Netherlands

In the Netherlands, most shelters for homeless people are provided by professional shelter organizations. In addition, some shelters are run by homeless persons themselves. Participants are in charge of the shelter and take care of the daily routine. A qualitative study was conducted to explore the value of consumer-run shelters for the persons involved, and to gain insight in the organizational incentives and disincentives to secure their existence.
Methods
The research followed a qualitative research design in which both in depth interviews and focus-groups were conducted with participants, social workers and policymakers. The research was carried out in close collaboration with participants in the shelters: they participated as co-interviewers in the focus groups and three feedback meetings were organized.
Results
The study revealed beneficial effects of consumer-run shelters on three levels:
1. They contribute to the individual recovery processes of its' participants. In consumer-run shelters homeless persons are responsible for both their own future and the shelter as a whole. The shelter contributes to the feeling of self- esteem, efficacy and identity transformation. Also, group processes in consumer run shelters facilitate peer support.
2. The relation 'care giver/care recipient' is fundamentally revised. In the shelters professional support is available (if needed), but the focus is on reflection and dialogue instead of protocols or EB interventions. The way this is done can be an example for professional care settings.
3. On the system level, the shelters reduce stigma of homeless persons (We can do it ourselves!) and can inspire other organizations how to work in a more recovery oriented way.
Discussion
The study contributed to a critical dialogue about how to organize care that will stimulate recovery processes. The challenge for consumer-run shelters is to guard their emancipatory ideology and independence, at the same time working together with professional organizations to secure their funding within in the dominant organizational and cultural framework. The professional and institutional paradigm often clashes with the 'do- it-yourself' paradigm of the consumer-run shelters. This challenge will be further explored in the case of JES ('Your own place'); a consumer-run shelter in Amsterdam.

Vicky Stergiopoulos
Meaningful inclusion of consumers in research and service delivery

Although participatory methods have become increasingly popular, people with lived experience of mental illness and homelessness have been historically excluded from service delivery planning and research. To better plan for the meaningful inclusion of consumers, this study examines lessons learned from the People with Lived Experience Caucus in the Toronto Site of the At Home/Chez Soi Research Demonstration Project on Homelessness and Mental Health.
Methods
The inclusion of the People with Lived Experience Caucus was evaluated using qualitative methods and multiple data sources, including review of 42 documents, 11 individual interviews, and 3 focus groups. Caucus members were included in the study team. Transcripts were analyzed using grounded theory methodology.

Results
Findings revealed a complex story of engagement for the People with Lived Experience Caucus: facing time constraints and given little direction, the Caucus developed through a tumultuous process related to both internal and external barriers to meaningful inclusion. Despite the challenges, the Caucus contributed meaningfully to various aspects of the research demonstration project.
Discussion
Suggestions for future initiatives hoping to meaningfully engage consumers include: early involvement, purposeful selection of members, clear communication of roles and responsibilities, a consumer coordinating group and space for critical dialog throughout the process. It is possible to successfully integrate psychiatric consumers with experience of homelessness in many aspects of research and service planning. Lessons learned can further guide the meaningful inclusion of consumers in similar endeavours in other jurisdictions

Anne Cooke
Challenging narratives about psychosis

"I thought that I had been given a life sentence" Jonny Benjamin
Many of those diagnosed with schizophrenia or psychosis find that the biggest barrier to recovery is not the psychotic experiences themselves but overcoming the 'narratives of despair'; that they often encounter both in services and in wider society. Anne will describe a current project that aims to challenge these. The British Psychological Society Division of Clinical Psychology will shortly publish a book-length report aimed at the public, service users and their families, policymakers and opinion formers such as journalists, together with clinicians. The report is entitled 'Understanding Psychosis; and Schizophrenia: Why people sometimes hear voices, believe things that others find strange, or appear out of touch with reality, and what can help'. Building on an earlier document, the report has been prepared by a working party of over twenty UK clinicians and researchers, together with service user contributors. Summarising current research and debate, it outlines different perspectives on psychosis; including psychological and social approaches as well as the traditional medical one. The title of the document reflects this - we deliberately chose not to entitle it; The causes and treatment of schizophrenia. The project is amongst other things an attempt to change the way these phenomena are viewed in UK society.

Session 1.2 Relationships that support recovery (Empowerment room)
Symposium - Recovery and clinical decision making in the treatment of people with severe mental illness across Europe (CEDAR).

Jana Konrad, Benjamin Mayer, Bernd Puschner
Content of clinical decisions and outcome in a European multicentre study of people with severe mental illness

Treatment decisions in the routine care for people with severe mental illness may cover a wide range of issues. This work examines change over time of content of clinical decisions, and the effect of course of decision content on outcome (unmet needs) controlling for confounders.

Methods
For the European multicentre study; Clinical Decision-Making and Outcome in Routine Care for people with Severe Mental Illness (CEDAR), 588 participants with severe mental illness were recruited from caseloads of outpatient/community mental health services from six European countries. Content of clinical decisions was examined using the Clinical Decision Making in Routine Care Scale (CDRC) at seven measurement points over one year. The decisions indicated by the patients were coded into content categories. Outcome was assessed using the Camberwell Assessment of Needs Short Appraisal Schedule (CANSAS). A mixed linear model for repeated measurements was used to examine effects of content of clinical decisions and time effects on outcome. Covariates included were age, duration of illness, clinical diagnosis, and study centre. To explore the impact of changes in decision content, a score ranging from 0 (always same content) to 12 (different contents on all assessments) was calculated.
Results
Content of clinical decisions was coded into six categories. The frequencies of decision topics only slightly changed over the time span of one year. No significant effects were found for the relation of content of clinical decisions and outcome. However, significant effects of assessment time point, duration of illness and study centre on number of unmet needs were found.
Discussion
Throughout high rates of making no decision may indicate patients having problems with defining decisions especially in the course of time. These difficulties may also explain the missing effect on outcome variables. There may be a general necessity in clinical practice to point out decisions as such.

Malene Bording, Signe Olrik Wallenstein Jensen, Helle Østermark Sørensen, Margareta Östman

Involvement in clinical decision making across professions: a six country European study

The patient-clinician encounter is an important aspect of mental health care, and the quality of this encounter impacts on outcome. Studies of clinical communication processes indicate patients and clinicians can have conflicting ways of accounting for the same problem and this affects the clinical decision making. The objectives of the study were to investigate patient involvement in clinical decision-making (CDM), according to clinician profession.
Methods
Data were collected as part of the CEDAR Study, a longitudinal study with bimonthly assessments filled out by clinicians and patients, collected over a 12-month observation period in six countries (Germany, UK, Italy, Hungary, Denmark, Switzerland).
Results
588 patients and their corresponding 213 clinicians participated in the study, providing a total of 2,608 patient assessments and 2,202 clinician assessments of patient involvement in CDM over time. Clinicians were divided into groups; 1) doctors, 2) psychologists, 3) care coordinators and 4) unqualified mental health workers. Results showed no significant change in patient involvement over time. However, we found a positive association between patient involvement and doctors experience, both when looking at patient ratings and clinician ratings. In spite of this association there is still a discrepancy between patients and clinicians rating of patient involvement in CDM.
Discussion
In this study there is little to indicate that clinicians' profession influences patient involvement in CDM. Clinicians' opinions and personal beliefs could be a dominant element in decision making, and this may have a bigger influence than staff profession, and can be a prime candidate for future targeted research.

Aniko Egerhazi, Marietta Nagy, János Nagy, Bernd Puschner
Context focused comparison of clinical decision making in European centres with regard to patient and clinician variables

According to previous studies it is rightfully assumed that both patients and medical staff members individual preferences in clinical decision making depend strongly on the context of the interaction itself. Several staff and patient variables influence the process of decision making. Shedding light on this issue was one of the research aims of the multicentre CEDAR study, sponsored by the European Union 7th Framework Program.
Methods
We have evaluated the decision making situation by measuring the amount of participation and information flow during the decision making process. This was enabled by specifically developed clinical decision making (CDM) measures, the CDMS questionnaires. As elements of the bio-psycho-social health model we have assessed context factors such as diagnosis, duration and severity of the illness, subjective quality of life (MANSA), outcome factors (OQ-45), helping alliance (HAS), and socio demographic data of both patients and staff (CSSRI-Eu). Correlation, factor analysis and linear regression analysis were carried out using the SPSS statistic programme.
Results
Six countries have taken part in the study with an enrolment of 548 patients treated by 212 health workers. The factors found significant in influencing CDM could be divided into five main groups: staff experience, general functioning, quality of life, helping alliance and patient age, with helping alliance proving influential regarding all CDM outcomes. The last three of these groups remained in the model even after including centre variables.
Discussion
Our findings suggest that the different centres vary significantly in the factors assessed, indicating the importance of specific features such as particularities of the health care systems. Helping alliance, however, remains the most important determining factor of participation and information flow in CDM regardless to the variability of the centres.

Eleanor Clarke, Bernd Puschner, Paul Williams, Mike Slade
Empowerment and satisfaction: multinational study of routine clinical practice

Decision-making between mental health clinicians and patients is under-researched. This study aims to test whether mental health service users are more satisfied with a decision made (a) using their preferred decision-making style and (b) with a clinician with the same decision-making style preference.
Methods
As part of the CEDAR Study (ISRCTN75841675), a convenience sample of 445 patients with severe mental illness from six European countries were assessed for desired clinical decision-making style (rated by patients and paired clinicians), decision-specific experienced style and satisfaction.
Results
Patients who were empowered (i.e. more involved in decision-making than desired) had higher satisfaction scores (OR 2.53, p=0.003, 95% CI 1.37-4.70). Patients making decisions with a clinician who preferred more active involvement from the patient than the patient preferred level of involvement had higher satisfaction scores (OR 3.02, p=0.004, 95% CI 1.42-6.39).
Discussion
A clinical orientation towards empowering, rather than shared, decision-making may

maximise satisfaction.

Sabine Loos, Mike Slade, Bernd Puschner
Recovery and decision making involvement in people with severe mental illness from six countries: longitudinal observational study

It is assumed that active involvement of service users in the treatment process is an important step towards clinical and personal recovery of people with severe mental illness. Yet, the evidence base for this assumption is limited. Thus, the aims of the study are (1) to identify stages of recovery, and (2) to examine whether decision-making involvement predicts stages of recovery at baseline and over time (one-year follow-up).
Methods
Data from 588 people with severe mental illness (SMI) who participated in a multicentre European study (CEDAR ISRCTN75841675) were analysed using latent class analysis and proportional odds models.
Results
A three class solution fitted best baseline data, indicating that participants cluster into one of three stages of recovery. Cross-sectional predictors of stage of recovery were gender, marriage, years in school, living situation, study site, patient-rated therapeutic alliance, and symptom severity. Clinical decision making involvement was identified as a significant predictor of change in recovery over time.
Discussion
Implications of these findings for clinical practice and research will be discussed with a focus of the role of involvement in decision making as a prominent factor for the recovery process of people with severe mental illness.

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Session 1.3 System transformation (Comm-unity care room)

Justine Karpusheff
Cultural activities for social isolation: how far does taking part generate social capital?

The perceived failure of community mental health care (the revolving door) has led to criticisms that users of these services may now be in the community, but not of the community. Acute services are increasingly looking beyond their own boundaries to other sectors, in particular the cultural, in order to increase service user social participation. This runs parallel to growing evidence suggesting that social contact can improve and sustain positive mental health. Partnerships between mental health care and the cultural sector are driven by an assumption that provision of cultural activities will inevitably generate social contact and in turn create protective resources or social capital. However, there is a lack of longitudinal research justifying these assumptions.
Methods
The unit of study can be described as a complex social intervention. Care services are partnering with cultural organisations to engage people in a range of participation opportunities. In order to understand the complexity of context on outcome, the research framework of realistic evaluation was chosen. This enables exploration of what it is about cultural activities that works or doesn't work for these people in these circumstances and

why. Within this framework, a mixed methods approach is adopted. Quantitative data is gathered from the payment by results record and social network analysis. Qualitative data is generated through interviews and participant observation. Six monthly data collection explores the cultural and social lives of 30 service users from Mersey Care NHS Trust.
Results
The paper will present findings from the first wave of data collection conducted from November 2013 to March 2014.
Discussion
The paper will aim to discuss how far taking part in cultural activities can create new or support existing relationships and what role cultural activities and care services play in helping to harness the recovery resources potentially generated by these relationships.

Galit Halperin
Community recovery: a key concept for social integration of people with mental illness

The notion of recovery is well established in the field of rehabilitation of people with mental illness and has focused, mainly on the internal processes with which the individual dealing with mental illness faces with himself and his environment. In this talk I would like to suggest a new concept: Community recovery, that refers to the multi-dimensional process occurring in the community in which people with mental illness are integrated. The concept of community recovery, complements the relationship between stigma and recovery. With regard to stigma it's common to refer to self-stigma and public stigma. However, with regards to recovery, the main focus is on the personal recovery; namely on the different processes which the individual deals with. The concept of Community recovery, proposes that in addition to the public stigma there are also powerful recovery processes in the community. As personal recovery, community recovery emphasizes the power and the ability of the community that could lead to the expansion of the community identity at the public and at the individual level. Community recovery also refers to profits of the community followed by the integration of people with mental illness. At the community level, the profit can be instrumental (economic; resource allocation) and ideological (the realization of the concept that believes that there is a place for all segments of the population). At the individual level, the profit can be direct (the integration of people with mental illness may serve as a model to the general population to express their personal difficulties and variance), and indirect (everyone knows a relative whom he would like to see integrated). These processes were promoted by the community centers in Israel. During workshops participants created masks under the theme of "Who's Behind the Mask", followed by a discussion that was held in the spirit of community recovery.

Sarah Pollock
Challenging the 'expert professional-vulnerable client' dyad through socially inclusive practice

The presentation is concerned with possibilities for service users to take up more agentic identities/positions in the context of social care service delivery. Drawing on the findings from a participatory service development project in a large social care organisation in Melbourne, Australia, the presentation asserts that existing oppressive dynamics in the service provider-service recipient dyad can be shifted by developing more inclusive ways of engaging with service users.
Method

The presentation draws on interviews with participants in a service development project in three settings: a group program for children whose families had experienced homelessness; support for people with disability with individual funding; and, an aged-care housing program for elders with histories of homelessness and mental distress. In each setting service users and family members, staff, managers and government administrators were facilitated to work together as equal participants throughout the service development process. Situated in rights-based approaches to health and social development, the analysis drew on Foucauldian conceptualisations of power that see the point of operation of power as the point of resistance, and therefore containing the possibility for change. *Results*
The participatory processes used in the service development project offered possibilities for service users to take up more agentic identities that were not available to them in the standard service delivery context. The shift in power, however, was difficult to sustain.
Discussion
The Foucauldian analysis of power relations enabled an exploration of the interaction between knowledge, power and identity and highlighted conditions that supported a move away from oppressive dynamics, as well as the difficulties of sustaining change in a complex organisational and policy environment. The approach taken in the service development projects is consistent with a recovery orientation, and the findings from the project appear to be applicable to wider health and social care service delivery contexts.

Vanessa Pinfold, Daryl Sweet, Richard Byng, Ian Porter
Connectedness and recovery: the role of practitioners in personal networks of people with severe mental illness?

We explore the contribution of social resources to managing wellbeing among people with severe mental illness (SMI) and assess the role(s) for practitioners in prioritising networks as a strategy for supporting recovery. A dimension of recovery is connectedness; our study explored individual connections to people, places and meaningful activities in order to understand networks beyond social ties and social support.
Methods
Within a mixed methods study we carried out 41 in-depth interviews, followed up from a sample of 150 participants with SMI whose connections to people, places and activities were mapped, 44 interviews with practitioners and interviews in 30 organisations. A synthesis of interview data was conducted with particular focus on practitioner role(s) within personal networks and implications for policy and practice.
Results
Individuals with SMI reported great heterogeneity in networks of place, person and activity reflecting differences in personal interests and capabilities which contrast with the focus on diagnosis, medication and risk management emphasised by many practitioners. However, practitioners feature as significant resources for individuals both those under specialist mental health care and those in primary care only. GPs, along with most psychiatrists did not see network development as their role. For those practitioners who did, service systems appeared to thwart their agency and create obstacles to person centred outcome focused care despite an overarching commitment to recovery focused practice in secondary care.
Discussion
While recovery practices focus primarily on social relationships to nurture connectedness and social inclusion it seems unlikely that people with SMI will be able to build personal networks that make full use of their own and other potential resources. Practices that embrace new structures, such as health budgets, and support individual life choices reflecting potential wellbeing impacts from personal connections to people, places and activity resources are lacking. Role(s) for practitioners need further exploration.

Glenn Roberts, Jed Boardman
How can psychiatrists support personal recovery: re-visioning training and professional development

The role and contribution of psychiatrists and psychiatric practice to personal recovery is controversial. Some people regard their problems as due to psychiatry but the majority of people with severe mental illness will come to treatment services led by psychiatrists. Developments in recovery justifiably emphasis their provenance from the service user movement and are centred on empowerment and self-determination. So how can psychiatry respond to this challenge to become more helpful and effective in enabling personal recovery? Roberts and Boardman have sought to answer this question in authoritative reviews guiding CPD for their colleagues which aim to inform, engage, challenge and inspire.

Method

One way of seeking to influence professional practice is through formulation, dissemination and discussion of theoretical positions and conceptual reviews. These can form a basis for training and development, and impact on professional curricula and evaluation. 'The rediscovery of Recovery' (Roberts and Wolfson, 2004) has become the most ever cited paper in the RCPsych's CPD journal Advances in Psychiatric Treatment. Ten years later Roberts and Boardman will be publishing 2 papers for their colleagues (due November 2013/January 2014) summarising international developments over the last 10 years and presenting psychiatrists with an overview of 'Understanding recovery' and a guide to, 'Becoming a recovery oriented practitioner'.

Results

Drawing on an international consensus there is now clear but provisional guidance on a core curriculum for training psychiatrists and mental health professionals to be recovery-oriented practitioners.

Discussion

This presentation will present a synopsis of this (by then) published guidance with an intention of provoking discussion!

Session 1.4 Keeping well in daily life (Hoping for more room)

Maggie Harmon
Living your truth

Based on my recently published book, 'til now: a memoir about growing up in an addicted home and finding my way to recovery and reality' I will present tools for both professionals to develop greater understanding of the impact on individuals of addicted environments, and for individuals to build on leadership skills and strength in empowering their own lives. (maggieharmon.com linkedin.com/maggieharmon)

Living with Psychosis: a Peer Specialist-and-clinician delivered programme for Recovery in Psychosis
Shane Powell, Rachael Sadler, Terry Bowyer

A Peer Specialist from the Dorset Mental Health Forum and 2 Thorn/CBT trained clinicians have been delivering a 10 week 'Living with Psychosis' course. The aims have been: 1. For the attendees to hear the Recovery Narrative of the Peer Specialist, and for the attendees to share ideas and support regarding how they live with their psychoses. 2. To deliver educational and clinical material about psychosis including triggers and distress-maintaining factors, and for each group attendee to develop their own relapse-management plan if they did not already have one. 3. For the attendees to be informed about the educative courses run by the Dorset Mental Health Forum.

Method

The sessions follow a structured format with the Peer Specialist (PS) narrating, each week, one particular aspect of his Recovery Narrative. This includes his experiences of paranoia, delusions, mood instability, poor motivation etc. He discusses how he manages these experiences, and the two clinicians then offer a clinical perspective of the experiences and also potential management strategies drawn from practical, easily-useable Thorn and CBT material. The group attendees are encouraged and assisted to reflect on the experiences and the clinical perspective, apply this information to their own lives, and potentially make changes in light of this.

Results & Discussion

The delivery of the Peer Specialist Recovery Narrative combined with the clinical material, and the interactive nature of the course, appears to work well. The attendees have reported positive, qualitative psychological changes which have included increased awareness and acceptance of their condition, the ability to use psycho-social and CBT techniques in order to better manage their condition, and changed (improved) relationship with the mental health services. A number of the attendees from the courses have gone on to attend Recovery Education Centre courses run by the Dorset Mental Health Forum.

Anneliese de Wet and Leslie Swartz

Hearing their voices: the lived experience of recovery from first-episode psychosis in schizophrenia in South Africa

Recovery in schizophrenia was regarded, for a very long time, as a somewhat unattainable goal. In addition, the de-emphasis of the subjective experience of the person living with schizophrenia created an environment where studies on the experience of recovery were disregarded. The dawn of the civil rights movement in the 1960s paved the way for the recovery movement in mental health. A new emphasis was placed on the person living with schizophrenia and his or her individual experience. Together with this, the deinstitutionalisation of long-term patients following the introduction of anti-psychotic medication allowed for recovery in schizophrenia to become a more widely accepted concept.

Methods

Against this background, this study seemed crucial and focused on how seven participants experienced their recovery from first-episode psychosis in schizophrenia. Each participant was interviewed twice, the interviews transcribed and then analysed with the use of Interpretative Phenomenological Analysis.

Results and discussion

It was found that support and its natural corollary, having to care for another, are possibly the greatest contributors to the recovery of persons faced with mental illness. Participants highlighted the important role of spirituality in their recovery, despite it being generally regarded as a controversial topic. Since spirituality has the ability to build resilience, it cannot and should not be overlooked. Stigma was found to be ingrained and pervasive, as it so often is for persons faced with mental illness. It can be a barrier to recovery. The retention or rediscovery of the abilities of those challenged by mental illness was seen as a determining factor for recovery, since it (re)introduces a sense of agency. In conclusion, and

without fail, all the participants agreed that talking about their experiences aided them. This points to the fact that there can be no question as to the value of the narrative in the process of recovery.

Miriam Goldberg, Orit Karnieli-Miller
The transition from patient to thera-patient for social work students with psychiatric difficulties

The purpose of this research was to explore the personal experiences of social work students with psychiatric difficulties. The exploration focused on the challenges they experience through their development as professionals. Social work students in general go through a process of developing a professional identity, this process maybe an even more challenging process for social work students who are dealing with psychiatric difficulties; however, this process has not yet been sufficiently studied. Therefore, the aim of the present research is to deepen the understanding of the complexities, the dilemmas and the professional developmental process of these students.
Methods
Immersion/crystallization narrative method including in-depth interviews with twelve social work students coping with diverse psychiatric difficulties was conducted. The interviews were carried out from an insider's researcher perspective as the leading researcher (MG) is a social worker coping with psychiatric difficulties, and therefore part of the research population.
Results
The findings reveal the challenging developmental process the students undergo from merely mental patients towards becoming thera-patients. This process includes four stages: An initial exploration of the health care world, questioning the possibility of a patient being a therapist and feeling incompetent, identifying their capabilities to be professionals and towards integrating between their patient and therapist parts- becoming a thera-patient.
Discussion
The findings from this research shed light on this important developmental process that students with psychiatric difficulties undergo, in order to allow them to maximize their potential as health care professionals, given they are provided with the right assistance and support. Understanding this process and aiding the student through it are critical in order to allow both of their parts, the patient and the therapist, merge together and inspire each other. Such guidance will allow the future integration of professional knowledge, self-care and personal experience.

Emma Lamont and Ruairi Lynch
Finally finding our voices: mental health nurses talk about their belief in recovery, overcoming stigma and building a positive sense of identity

The purpose of this study was to undertake a critical inquiry into the concept of recovery, through a detailed examination of the thoughts and views of mental health nurses who have lived experience of mental health difficulties. By doing so, the study will draw upon their understanding and provide new perspectives further developing our understanding of mental health recovery.
Method
This was a qualitative research project whose methodological approach lies in describing the social reality and lived experience of people. As such, a narrative inquiry was undertaken with six mental health nurses, recruited through an article on the Scottish Recovery Network

website. An informal interview enabled them to tell their story. Results Narrative analysis resulted in developing 66 poems along with a short 3 minute digital story of their collated words available: http://www.youtube.com/watch?v=p1nmLswaF9g. These drew upon the themes; connectedness, hope and optimism, identity, meaning and empowerment. The mental health nurses spoke about building hope inspiring relationships. Their accounts illustrate peer support and lived experience being offered subtly as a tenet for theirs and others recovery. They also spoke of overcoming the internal stigma "The worst is your internal stigma and the shame you feel when you are depressed". The same participant spoke of his role in becoming a social activist to overcome stigma, encouraging others to do the same; "In the last year I can think of 6 colleagues who have talked about their mental health, their own experiences, their own stress, and that makes you feel really good, to share that with somebody else, it makes me think, it's good to talk. We shouldn't hide it" (Fraser)

Discussion

This study is an account of a qualitative research project exploring the views, thoughts and feelings of mental health nurses who have lived experience, to understand how they conceptualise recovery. By doing so, their unique perspective allows further development and understanding around the philosophy of recovery. It also facilitates drawing mental health nurses into the recovery discussion and presents an alternative perception of their identity, strengths, challenges and potential value.

Parallel Session 2 – 2.20pm Monday 2nd June

Session 2.1 Relationships that support recovery (ReThink room)
REFOCUS symposium

Mary Leamy, Victoria Bird, Julie Williams, Mike Slade
Overview of REFOCUS intervention

To develop a theoretically-based and empirically-defensible new pro-recovery intervention called the REFOCUS Intervention.
Method
Seven systematic and two state-of-the-art reviews were undertaken. Identified evidence gaps were addressed in three qualitative studies. The findings were synthesised to produce the REFOCUS Model.
Results
The REFOCUS Intervention comprises two components: recovery-promoting relationships and working practices. Relationships are addressed by skills training for staff in coaching, developing a shared team understanding of personal recovery, exploring staff values, a Partnership Project involving people who use the service, and raising service user expectations. Working practices are Understanding values and treatment preferences, Assessing strengths and Supporting goal-striving. The REFOCUS Model describes the causal pathway from the REFOCUS Intervention to improved recovery.
Conclusions
The REFOCUS Intervention is an empirically-supported pro-recovery intervention for use in community mental health services. It will be evaluated in a multi-site cluster randomised controlled trial (ISRCTN02507940).

Eleanor Clarke, Mary Leamy, Mike Slade, Genevieve Riley
Staff perspectives of the REFOCUS intervention

The REFOCUS intervention is a whole team, complex intervention aimed at increasing the recovery support offered by community based, mental health staff. The intervention and associated implementation strategy consists of (a) activities to develop and support the working relationship between staff and service users and (b) three working practices to increase recovery support. This paper investigates the experiences of staff allocated to the intervention arm of the REFOCUS Trial (ISRCTN02507940). The two objectives are to understand staff perspectives on (a) the REFOCUS intervention as a whole, and (b) the individual components of the Refocus intervention.
Method
28 Semi-structured individual interviews and 4 focus groups with staff from REFOCUS intervention teams were carried out. Thematic analysis was conducted to elicit over-arching themes.
Results
Regarding the intervention as a whole, staff discussed four main themes: empowerment; developing therapeutic relationships; professional development and team dynamics; and frustration and lack of clarity. Specific components of the intervention staff were especially positive about were: coaching training: the values and treatment preferences guide; and the strengths approach.
Discussion

Staff had varied experiences of the Refocus intervention. Recommendations will be made for candidate modifications to the REFOCUS Model and the REFOCUS intervention.

Genevieve Wallace, Victoria Bird, Mary Leamy, Mike Slade
Service user experiences of the REFOCUS intervention

An understanding of service user experiences of recovery-focused interventions such as REFOCUS is important to any service aiming to provide recovery-orientated care. This study investigated the experience of service users who received the REFOCUS intervention, focusing on the impact of intervention components on the working relationship and on personal recovery.
Methods
Interviews (n=24) and two focus groups (n=13) were conducted with a purposive sample of individuals from the intervention arm of the REFOCUS intervention (ISRCTN02507940). A coding framework was developed using thematic analysis.
Results
The data were organised into four superordinate themes: intervention tasks and activities, working relationship which supports recovery, outcome for the person using the service and lack of noticeable change in experience of person using the service. When successfully implemented the REFOCUS intervention facilitated the building of a mutually trusting and open working relationship, in which service users felt staff were interested in them as a person. Service users also felt more empowered, hopeful, and developed a more positive self-image. However some individuals experienced the working practices without being made aware of their purpose, and/or in the absence of a recovery-promoting relationship, experiencing them as intrusive or non-beneficial.
Discussion
Understanding which features of the intervention were successful from a service user perspective not only enables us to evaluate the REFOCUS model and intervention, making recommendations for possible modifications, but will help clinicians to translate and adapt elements of the intervention into their routine practice.

Victoria Bird, Mary Leamy, Tom Craig, Mike Slade
A cluster randomised controlled trial of a recovery intervention for black individuals who use community mental health teams

Despite an increased emphasis on personal recovery within mental health services, the recovery literature has been described as monocultural, with little empirical research regarding the efficacy of recovery interventions of individuals from black communities. In a previous study, we developed the framework of recovery support developed from qualitative interviews and focus groups with black individuals who used adult community mental health services, Part of the REFOCUS intervention was developed on the basis of this framework. This study aims to test the efficacy of the REFOCUS intervention within a pre-planned randomly selected sub-group of black individuals within the REFOCUS Trial (ISRCTN02507940).
Method
The impact of receiving the REFOCUS intervention in addition to standard care was evaluated in a cluster randomised controlled trial. The unit of allocation was the community mental health team. Outcome was assessed for black (African, Caribbean, Black British or Black other) service users with a clinical diagnosis of psychosis. Standardised measures of satisfaction with care and personal recovery were the primary outcomes, and service

support for recovery, hope, quality of life, service receipt and symptoms were secondary outcomes.
Results
Eighteen teams participated in the REFOCUS Trial, with nine allocated to the intervention. 118 mental health service users from black communities participated. The results will present the findings from the trial specifically in relation to measures of personal recovery and satisfaction with care.
Conclusions
This trial represents the first randomised controlled trial assessing a recovery focussed interventions for people from black backgrounds. In order to be more recovery-orientated, understanding the perspectives and experiences of people from minority ethnic communities is fundamental in enabling services to match the needs of the diverse communities they serve.

Julie Williams, Mary Leamy, Mike Slade, Francesca Pesola
Development and testing of INSPIRE measure

INSPIRE has been developed to measure staff support for recovery by service users. Little is known about the relationship between staff support for recovery and self-identified recovery. INSPIRE was used in a Randomised Controlled Trial (RCT) with 403 service users to examine this relationship. *Methods*
The REFOCUS RCT was a 12 month intervention aimed at increasing the recovery orientation of services. 27 community mental health teams across 2 NHS Trusts participated with 14 teams in the Intervention arm and 13 in the control arm of the trial. 15 service users were chosen at random in each team to complete outcome measures including INSPIRE and a questionnaire of recovery (QPR) at baseline and follow up.
Results
INSPIRE and QPR scores will be evaluated to look at any correlation. Possible mediators such as gender, ethnicity, and length of time in services will be considered.
Discussion
INSPIRE is a new measure of staff support for recovery. This presentation will discuss the association between service-user rated staff support for recovery and recovery itself. This will provide new information on how staff for support for recovery is received and the effect this has on recovery. Any possible mediators will be discussed in relation to the implications for how staff support recovery.

Session 2.2 Relationships that support recovery (Empowerment room)

Mary O'Hagan
PeerZone – peer led workshops in mental health and addiction

PeerZone is a series of 19 three hour peer-led workshops in mental health and addiction, backed up by online resources and support services for facilitators. It was developed by Mary O'Hagan and other peers. The workshops explore distress, recovery and all the major life domains such as lifestyle, relationships, housing and employment. We have certified 59 certified PeerZone facilitators in Australia and New Zealand in 2013 and 87% of workshop participants have rated them as excellent. Peer Zone is going to other countries in 2014. PeerZone works on three levels in individual participants: It invites them to rebuild a more

positive story of their lives; it offers tools for whole of life wellbeing; it creates a community of mutual support. This talk describes the journey of PeerZone from the initial idea to the latest developments and the philosophy behind it, based on peer support and recovery values.

Steve Gillard, Sarah Gibson, Jess Holley, Mike Lucock
New peer worker roles in mental health services: modelling the mechanisms of change

Peer Worker roles are being introduced into mental health services in a variety of forms. There is qualitative and pilot study evidence that indicates the benefits of Peer Workers for the people they support but formal trial evidence in inconclusive, in part because the change model underpinning peer support is underdeveloped. There is a need to model, theoretically and empirically, how the mechanisms underlying Peer Worker-based interventions are associated with change in outcomes. *Methods*
In a qualitative, comparative case study of 10 Peer Worker-based initiatives in statutory and voluntary sector mental health services in England in-depth interviews were carried out with 91 Peer Workers, service users, co-workers and managers, exploring their experiences of peer working. Using a framework analysis approach we identified core processes within the Peer Worker role that were productive of change for people supported by Peer Workers. Service user researchers were integral members of the research team, guiding and undertaking the research.
Results
Key change mechanisms included: i) building trusting relationships on the basis of shared lived experience; ii) role-modelling individual recovery and living well with mental health problems; iii) bridging and engaging service users with mental health services and the wider community.
Discussion
The mechanisms identified in our data were further supported by relevant theoretical literature on role-modelling (Social Learning Theory) and relationship in mental health services (Therapeutic Alliance; Attachment). The wider peer support research literature is suggestive of how those mechanisms might be associated with a range of individual recovery and service use outcomes. This enabled us to build a change model that explains how Peer Worker interventions support individual recovery journeys and improve mental health care pathways. This model potentially informs the future development of Peer Worker roles and the design of studies to formally evaluate Peer Worker interventions in mental health services.

Ruth Chandler and Simon Bradstreet
Voicing caregivers experiences of recovery and wellbeing

Voicing Caregivers Experiences was a joint project, developed to address a perceived gap in the involvement of caregivers, such as family or friends, in efforts to promote and support recovery across the UK. This partnership project was run jointly Sussex Partnership NHS Foundation Trust and the Scottish Recovery Network.
Methods
Existing networks and contacts were used identify contributors, five in Scotland and five in Sussex. We worked with the authors throughout to set the direction of the project and agree the editing process for the book, which was the primary output. Meetings were held with contributors at both sites at the start of the project to agree the aims and approach of the project. An informed consent approach was employed and levels of support for the

development of narratives were defined by individual needs and wishes. Narrators' interpretive agency was maintained through, for example, contributors deciding what was most important, which was used as a frame for the analysis. A second authors meeting was hosted in Scotland towards the end of the project which, along with individual feedback from Sussex, was used to frame the concluding discussion and to provide a renewed emphasis upon wellbeing.
Results
There were very mixed views on recovery and wellbeing from contributors both as a concept in the lives of the contributors and when considering the person for whom they cared. Experiences shared suggested that as we try to make recovery in the triangle of care we must further emphasise.

Sandy McNeil
Changing relationships in family-centred care

An international focus on Family-Centered Care (FCC) in mental health has resulted in a variety of recommendations designed to increase family involvement in promoting the recovery of loved ones. These studies call for a shift in organizational practice from one of expert professionalism to one of knowledge exchange and partnership. This study explores how family members describe and understand their experiences with the mental health system, and provides a critical analysis of their experiences, considering ways in which subtle discrimination may be operating to impede recovery. *Method*
A qualitative, exploratory study using in-person interviews has been implemented. The sample includes four family members in Ontario, Canada who are currently supporting relatives with mental health issues. A critical, Foucauldian theoretical framework is applied to the data to expose hidden systems of domination and oppression, which may interfere with FCC.
Results
Family members in this study identify a significant lack of collaboration, information and support from the mental health system, often due to confidentiality concerns and funding limitations. At the same time, family members are hesitant to identify discrimination as a primary obstacle to FCC. It appears that processes may be operating to elicit the participation of family members in the reproduction of discrimination.
Discussion
A critical, Foucauldian analysis of family narratives allows for the deconstruction of dominant biomedical, psychiatric and neoliberal discourses, which create binary identity constructions of expert/non-expert, functional/dysfunctional, and responsible/irresponsible citizens who are co-opted into the management of their loved ones. Recommendations for resistance include cultivating a critical awareness to disrupt dominant assumptions that inform discriminatory attitudes and practices. The goal is to recognize complicity in perpetuating inequality and strive to develop egalitarian power relations among service providers, family members and people with mental health issues, thereby promoting ongoing recovery and wellness.

Julia Pelle
African and African-Caribbean carers experience of supporting recovery in relatives with psychosis

Several government reports indicate that there is a high incidence of enduring mental health problems in the African and African Caribbean communities living in the UK. Although research has explored the experience of service users from both of these communities, little

is known about how family carers experience caring for a relative with an enduring mental health problem from the same communities. The aim of this investigation was to explore the lived caring experience of seven carers from the African and African Caribbean communities who cared for family members with an enduring mental health problem.
Methods
A hermeneutic phenomenological approach, as described by Van Manen was used, which encompassed descriptions of carers experience of caring and subsequent interpretation of their lived experience.
Results
Results reveal the caring experience to encompass six themes: (i) a strong reciprocal sense of family based on traditional family ideologies; (ii) the significance of a multi-family approach to caring; (iii) the need for carers to have their own personal space to reflect on their carer journey and to assess the impact of the carer role on their relatives recovery from mental illness; (iv) fears that care delivered to their relatives was influenced by negative cultural stereotypes; (v) carers use of local community groups to assert their carer role and (vi) a desire for partnership with mental health and social care services that includes a family based approach to care.
Discussion:
The process by which carers sustain hope in the caring experience, links to their focus on the achievement of their relatives through an adverse illness experience. This study found that although carers were motivated to care for their family members, they were equally keen to work in partnership with mental health and social care services to maintain family traditions and support recovery of their relatives.

Session 2.3 System transformation (Comm-unity care room)

Triona McCaffrey
Evaluating music therapy through art, song and words: a service user perspective

Central to the recovery philosophy is the acknowledgment that service users are experts by experience who have valuable contributions to make in informing healthcare provision. This paper will describe the final stages of doctoral research that attempts to bear witness to the views of those who have attended music therapy in mental health care in Ireland. Triona is a member of the 'Music and Health Research Group' at the Irish World Academy, University of Limerick.
Methods
Qualitative methods were used to evaluate music therapy in two statutory funded mental health settings. A series of individual interviews was carried out with service users who described their experiences of attending music therapy in an in-patient setting and the interview transcripts were analysed using interpretative phenomenological analysis. The second stage of this research pursued a non-verbal approach to music therapy evaluation by carrying out group workshops in which service users employed arts-based research methods to reflect upon their experience of attending music therapy in a mental health day centre.
Results
Findings from service user interviews provide a rich verbal description of the individual life-world in music therapy. This description is further enhanced through a presentation of visual and audio-visual artworks created by service users who wish to share their experience of attending music therapy using non-verbal means of expression.

Discussion
Findings from these multiple perspectives of music therapy will enable a thorough exploration of factors which affect meaningful service evaluation and successful inclusion of service users in development processes. These findings will not only be relevant to the profession of music therapy but also to other allied health care professions who wish to encourage meaningful service user involvement in health care delivery.

Nick Dent and Lyndsey Wall
Using appreciative enquiry in developing recovery oriented practice

KMPT identified a need to support service users' full engagement in planning their care with staff, focusing on 2 areas of care planning that national patient survey results indicated a need to improve. These were ensuring people's views are taken into account when planning their care, including the goals that the service user would identify for themselves in care plans and ensuring service users have time to consider their condition and treatment. These matters are also central to recovery focused practice.
Methods
We used Appreciative Enquiry to build on the positive experiences that many service users and staff have in successful engagement to identify ways of improving practice overall. Our project was collaboratively delivered by a team of staff and service users trained in AE who worked in pairs engaging individuals and groups of service users and staff considering participants' positive experiences of care planning and how these can be further developed to achieve the identified aims of service improvement. Each interview covered the 4 AI phases of Discover, Dream, Design and Delivery.
Results
27 service users and staff members were recruited and trained and together engaged 57 participants in interviews and group consultations. Team members met regularly to share findings and develop understanding around the key themes arising from engagements which were then shaped into a report which identified 14 recommendations for change. These have now been shared with the senior management of the trust who are working to implement these recommendations
Discussion
AE is an effective tool in supporting organizational change and could be used more widely in supporting the development of recovery oriented practice, as it builds of current good practice and is values driven. Working collaboratively can also bring service users and staff together to bring about cultural change, build relationships and support enhanced understanding.

Louise Christie and Simon Bradstreet
Results from implementation of SRI2: a national recovery improvement initiative

Scottish Recovery Indicator 2 (SRI 2) is a service development tool which is designed to support mental health services to enhance recovery approaches. Data collected through SRI 2 provides a unique insight into the recovery focus and person centredness of Scottish mental health services. *Methods*
A detailed internal review of the first 14 months of SRI 2 data was completed. This included a review of participating service characteristics, an assessment of quantitative data on specific indicator ratings and qualitative data produced as part of the action planning process in services.
Results

There was a significant level of activity and reflection by the 112 included services over the 14 month period. 831 assessments and 740 care plans were reviewed and views sought from 575 service users, 306 informal carers and 501 practitioners. The average overall score generated by services completing SRI 2 was 3.8 out of a total of 5. The range of scores was limited and there is some evidence to suggest positive appraisal amongst services completing SRI 2. While the quality and detail of the action plans reviewed varied, some key themes have emerged.

Louise Christie and Simon Bradstreet
Enhancing recovery in a voluntary sector mental health provider

The Scottish Recovery Network and SAMH, a large Scottish third sector social care provider, worked together to deliver a project to enhance recovery approaches in 13 supported accommodation services. The project was designed to encourage more strengths based and recovery focused approaches, with the aim of improving outcomes for service users. A key feature of this project is the use of the Scottish Recovery Indicator 2 (SRI 2).

Methods

The project comprised a number of elements including tailored training and support for all managers and staff and the completion of an SRI 2 review process in each service. Evidence of changes made through the SRI 2 review were collected by each team and views were also gathered through a series of focus groups. Additionally all staff completed pre and post surveys of recovery attitudes, knowledge and values.

Results

With regard to the use of SRI 2 it was clear that the self-assessment nature of the tool promoted a process of engagement and reflective discussion and enabled a high level of buy-in by staff. Completing an SRI 2 was a learning and development experience for staff as individuals as well as for services. A small number of key themes emerged. While there was good awareness of the importance of collaborative goal setting it was recognised that this was a highly skilled process. A reassessment of risk management procedures and attitudes within a recovery framework and better addressing recovery and move on with service users was also identified.

Discussion

This project has informed efforts to enhance recovery approaches in social care settings. It also provides strong support for the collaborative nature of the SRI 2 process and suggests that this type of structured approach to recovery focused service improvement, including but not limited to SRI 2, is worthy of consideration.

Session 2.4 System transformation (Hoping for more room)

Stephanie Daley, Mike Slade, Sube Banerjee
Implementing recovery within older people's mental health services – What are the issues?

Despite the emphasis on recovery in services for working age adults, equivalent developments and research in older people's mental health services have not yet taken place. A qualitative study was undertaken with 28 service users and 10 carers, which produced a conceptual framework of recovery for older people with mental health problems (Daley et al, Int J Geriatr Psychiatr, 2013). This framework highlighted similarities and

differences in the experience of recovery for older people, and was used to develop an intervention (a 3-day team-based recovery training package and implementation support for staff working within older people’s mental health services) and intended effects. A pilot study was undertaken to optimise the intervention and evaluation strategy, and to define the trial parameters of a future definitive trial.
Methods
The intervention was delivered to 204 staff working in 15 clinical teams in South London, UK. The hypotheses were that intervention would improve recovery and quality of life for service users. Outcome evaluation used a controlled pre/post design, with 103 service user participants at baseline across three time points, using the Illness Management and Recovery Scales (Mueser et al, 2004) and two quality of life measures. Process evaluation comprised: qualitative interviews with staff and trainers (n=15), pre-post staff ratings (n=176) of recovery knowledge and attitudes, fidelity assessment and an audit of care plans (n=1574).
Results
The hypotheses were not confirmed. The process evaluation highlighted significant change in recovery knowledge, but change in other candidate mediators was not demonstrated. The significance of the fit between trainer and team, team organisational culture, team and organisational readiness for change and professional group membership were identified as significant factors in the development of pro-recovery culutre change.
Discussion/Conclusion
Recovery measures suitable for use with older people are needed. Improved strategies to implement the intervention to team and professional group context are required.

Helen P Hamer and Sarah Viggiano
Upholding the contract: supporting the citizenship status of people who use mental health services

This paper will present the outcome of a small scoping study that advances the initial findings of Hamer (2012) and her recommendation that an overarching citizenship framework is required to underpin contemporary mental health practice.
Method
This study used a modified Delphi method to explore the constituent parts of a citizenship framework that could underpin mental health practice. Seven expert panel members (service users, academics and clinicians) were recruited in both Australia and New Zealand. In response to three rounds of written discussion (via email) qualitative data were analysed using a thematic analysis.
Results
The findings from this small scoping study highlighted 3 themes: risk, reflection and relating. Participants reported that mental health professionals want to actively support the citizenship status of the people they serve. Findings indicate that systems changes which uphold the principles of the social contract between the user of services, the mental health professionals and their employers are required.
Discussion
People with mental health problems have the right to access services that foster their autonomy and personal agency to maintain their mental and physical wellbeing throughout their journey of recovery. Participants argued that mental health professionals can ensure that the citizenship status of the people they serve is further upheld when reciprocal relationships between employee and employer are embedded within service delivery. Hamer, H. P. (2012). Inside the city walls: Mental health service users' journeys towards full citizenship (Unpublished PhD). The University of Auckland, Auckland, New Zealand. Retrieved from https://researchspace.auckland.ac.nz/handle/2292/11915?show=full

Bridey Rudd, Jane Cumming, Nigel Henderson, Scott Hardie
Enabling transformation within a Scottish mental health charity

Principles of personalisation and recovery are shaping the direction of service provision in Scotland. Mental health charity Penumbra has embraced the challenge of transforming their service provision in order to deliver a personal outcomes based approach, engaging in systems transformation in order to achieve the following cultural shifts:

- People who use services move from being passive recipients of support to students of their own wellbeing.
- Penumbra staff move from delivering support to offering coaching & education
- Penumbra aims to move from pre-defined services to personalised, outcomes-based service
- Measuring outputs to measuring meaningful outcomes

Method

Shifts have been facilitated through the implementation of an outcomes focused approach and supported by new posts, changed roles, revised training programmes and the development and implementation of the HOPE framework: HOME, OPPORTUNITY, PEOPLE and EMPOWERMENT. The framework includes the HOPE Toolkit, a range of personal plans, tools and wellbeing tips that promote a focus on personal outcomes, self-management and strengths based practice. It also includes Penumbra's recovery outcomes measure: the Individual Recovery Outcomes Counter (I.ROC), a 12-item recovery questionnaire which has been through successful initial validation testing, and is now being used throughout Penumbra and further afield.

The impact of implementing the HOPE framework has been examined in a multi-faceted study, including a staff knowledge questionnaire, focus groups and analysis of routinely collected data.

Results

Here we focus on the process of implementing the HOPE framework of support, and how it has impacted on staff. We will evaluate the extent to which Penumbra's culture has actually evolved, drawing on the results of the questionnaire and focus groups, and analysing changes in the data over time.

Discussion

We will discuss conclusions that can be drawn from our experience of the process of transforming a system towards a recovery-focused, outcomes based method of working.

Samantha Adkins, Sarah Williams, Phil Morgan
Exploring student and trainer experiences of Dorset's Recovery Education Centre

Recovery Colleges and Recovery Education Centres (REC) are being developed across the UK, with Dorset being one of the first. Central to their philosophy is the partnership working between professionals and experts by experience (CMH 2010). Despite this development of Recovery Colleges there is little literature that explores the experience of people participating in Recovery Colleges in the UK. Therefore it was decided to undertake two studies exploring both the experience of students and trainers.

Method

Participants were students (n=10) and trainers (n=7) who took part in the pilot term of the REC. Semi-structured interviews were conducted and analysed by Post-Graduate Psychology students who received training in qualitative interviewing and who had no experience of the REC or surrounding literature. The data was analysed using grounded theory.

Results
Themes from students' experiences centred on 'Motivation to Attend Courses', 'Gaining Recovery Support', 'Social Support' and the 'Impact of the REC'. Attending REC courses had a positive impact on beliefs about mental health and increased personal opportunities. These findings mirrored those of the experience of trainers for whom the overarching theme was the 'Philosophy of Recovery' and how it was embedded through the educational interaction between students and trainers. Three further themes: 'Education for All', 'The Tutor Partnership' and 'The Student Community' detail the processes by which the interaction occurred. Both groups highlighted the partnership working between professionals and experts by experience combined with the feedback from students provided a rich educational experience for all. The studies concluded that the REC showed promise as an approach to delivering mental health care.
Discussion
We will present the emergent themes from both students and trainers with reference to the guiding principles of Recovery Colleges and consider areas of possible further work including understanding the process of co-production between professionals and experts by experience.

Anthony Stratford and Sarah Pollock
Challenges and rewards of a recovery college down under

Mind Australia's establishment of the first Recovery College in the Southern Hemisphere represents a bottom up approach to system reform. The development of the College was informed work undertaken in the UK and adapted to the Australian funding and service environment. This presentation will explore the particular challenges in the Australian context, how our model of co-production has been developed to meet these challenges and the opportunities for the College to contribute to and inform system change. This presentation is a reflection on the development of the College to date drawing on documentation produced by the College operations including data about College activities, policies, strategic documents and governance records. We will also outline the model of co-production that underpins all College activities and operations, and describe how this has developed to meet the particular challenges outlined below. Mind has identified and is working on three major challenges. The first is the structure of the service systems that support recovery, including the specialist/clinical mental health services, the community managed psychosocial support organisations and more broadly the community services (or social care) organisations. The second is rechannelling and availability of new funding particularly the implementation of the National Disability Insurance Scheme (NDIS). Finally, the tyranny of distance and small population centres. The model of co-production has created strong, local partnerships for development and delivery of College courses. These are situated within broader, strategic relationships with government, philanthropy and a specific partnership with a large clinical service in metropolitan Melbourne. Both the NDIS and the recommissioning of psychosocial services in Victoria offer a great opportunity to expand the ways in which the College can support recovery as the system moves to a more self-directed approach. By centering the lived experience, for Mind Australia, as the largest community managed mental health organisation in the country, it offers a great opportunity to drive culture and practice change.

Parallel Session 3 – 4pm Monday 2nd June

Session 3.1 Relationships that support recovery (ReThink room)
Shared decision making symposium

Shulamit Ramon, Sheena Mooney, Nicola Morant, Clare Mundell
Shared decision making in mental health services

Medication is a key intervention in mental health, associated with problematic issues. User involvement is accepted as key to recovery oriented services, turning shared decision making (SDM) concerning medication central in current psychiatric practice and research internationally. There is a need to establish the value of SDM for enhancing partnership relationships between service users and clinicians, and construct evidence based effective interventions that successfully support SDM. The presentations in this sympoisum explore the potential for, and the enablers and barriers of SDM. *Methods*
Methodologically three of the presentations constitute participatory action research projects, with a defined intervention aimed at increasing SDM in practice (Mooney(UK), Baker UK), Zissman-Ilani (Israel)). Two of these projects have elaborate pre and post intervention evaluations, with measures of conflictual decision making, recovery, attitudes to drug taking, cost effectiveness and supporting the implementation of the process of SDM in actual practice. The fourth paper focuses on the evaluation of the first project (ShIMME) (Morant). The fifth presentation looks at aspects of organisational change triggered by the introductionof SDM, based on in-depth qualitative study of the changes that took place in UK NHS trusts (Markwick).
Results
The results of each project will be outlined in the presentations. A common them is the importance of trusting and respectful relationships between service users and clinicians, especially psychiatrists, as the enable of the shift to SDM. Another key finding is the endorsement of the desire to achieve SDM, coupled with outlining a long list of barriers and only some enables to reach it from all partners, particularly from clinicians.
Discussion
The discussion of the interventions and their effectiveness highlights the challenge of introducing SDM systematically alongside different types of knowledge, power, and the impact of long term conflictual relationships, for the purpose of securing a truly recovery oriented mental health system.

Elina Baker
Implementing recovery-focused prescribing and medicines management in practice

Recovery has been widely adopted by mental health services but there is a need to specify how broad values and principles can be translated into practice in specific areas. Over the last five years, a project has been taking place with Devon Partnership NHS Trust to develop and implement recovery based practice guidelines for prescribing and medicines management, which have previously been presented and published. Many aspects of these guidelines reflect the use of a Shared Decision Making approach and more recent work to support the implementation of the guidelines has focused on promoting the use of Shared Decision Making.
Method
The implementation phase of the project has had two strands: work to change the practice of

prescribers and work to support people taking medication in becoming more informed and confident to actively participate in prescribing interactions. The presentation describes the development of reflective practice workshops for prescribers. It also describes a number of strategies used to make information about medication more accessible and the development of 'How to talk to your psychiatrist workshops'.
Results
A number of barriers to shared decision making were identified through the process of the workshops, including a belief that no change was necessary, concerns about risk and capacity, time constraints and organisational demands. A number of potential strategies for overcoming these barriers were also identified. Routine patient experience data is being used to evaluate the impact of this work and has shown some positive changes.
Discussion
Competing organisational priorities may limit the extent to which prescribers feel able to fully engage in shared decision making. There is a need for more focused evaluation to provide evidence of effectiveness and gain organisational support.

Sheena Mooney, Mary Jane O'Sullivan, Fiona Blake, Shula Ramon
The development and implementation of the "ShIMME" training intervention to promote shared decision-making in psychiatric medication management

The ShIMME research project grew out of a user-led community initiative to encourage dialogue, choice and empowerment in decisions relating to psychiatric drugs. This, the first of two presentations about ShIMME, considers the background, planning and implementation of the training programmes. It is followed by Nicola Morant's presentation on the mixed-method evaluation of the ShIMME intervention.
Method
The research group included service users, psychiatrists, nurses and peer workers as well as researchers and the study was located in the Trust's Rehabilitation and Recovery pathway. When considering how best to ensure genuine shared decision-making, it was agreed we would provide training sessions to key groups involved in the process. Following a consultation phase, parallel training programmes were devised for people being prescribed medication, for psychiatrists and for care coordinators. We recognised that, though there would be overlap in what was being presented, each group would also have separate issues to address. The training for service users and for psychiatrists was co-delivered by a service user and psychiatrist, while a service user and a nurse prescriber delivered the training for care coordinators. A dedicated website was developed, including acted scenarios and other tools to aid shared decision making, all of which supported the training. *Results / Discussion*
The presentation will look at all aspects of the training programmes: the consultation phase; the process of development; working relationships; recruitment of participants; content and delivery and how the training was received. A more detailed evaluation will be presented by Dr. Morant.

Nicola Morant, Alex Collis, Ben Perry, Shula Ramon
A mixed-method evaluation of the "Shimme" training intervention to promote shared decision making in psychiatric medication management

The Shimme project developed, delivered and evaluated a training intervention to promote SDM for psychiatric medication in adult community psychiatric services. This was delivered to separate groups of service users, psychiatrists and care co-ordinators.

Method
We used a mixed-methods process and outcome-oriented approach to evaluate the impact of the intervention. As this is a pilot study, an uncontrolled pre-post comparison with a 12 month follow-up was used. Three sources of data were collected: i) The acceptability and feasibility of the training intervention were assessed by asking all participants and facilitators to complete feedback questionnaires immediately following the training. ii) The intervention's impact was assessed using validated questionnaire measures before training and 12 months after completion. These assess service users' and psychiatrists' preferences for and experiences of medication-related decision-making; psychiatrists' interactive style in decision-making processes; the quality of therapeutic relationships; and service users' attitudes to medication. The health economic impact of the intervention was assessed using a validited measure of service use at baseline and follow-up. Basic socio-demographic, clinical and work role data were also collected. iii) More in-depth explorations of the intervention's impact on medication experiences and management, and on clinical practices were obtained in semi-structured interviews with samples of service users and practitioners at 12 month follow-up.
Results / Discussion
Forty-seven service users, 35 care co-ordinators and 12 psychiatrists received the training intervention. We will present findings from the three data sources above. Implications for the success, future development and replicability of the Shimme training programme, and organisational barriers and facilitators to implementation will be discussed.

Anne Markwick
Organisational change, recovery and shared decision making

In order for mental health services to become Recovery orientated we need to move from relationships biased towards traditional professional expertise to more equal relationships centred around shared decision making and biased towards the person's own self-knowledge, sense-making and personal goals in the context of their whole life.
Method
Action research was used involving cycles of inquiry into what constitutes Recovery orientated practice, what challenges organisations face in introducing this way of working; how traditional practice differs from this orientation and what barriers to change might exist.
Results
Models for Recovery orientated practice were developed which gave insights into what Recovery orientated practice involves, what might contribute to it and what might hinder it both for the person using the service and the professional. Recovery orientated relationships will be based much more on a coaching/consultative approach than that of the traditional medical approach. Professionals will become a resource to be used rather than the expert at the centre. Shared decision making is central to this approach.
Discussion
The qualities of practitioners who are able to work towards Recovery and shared decision making include curiosity and belief balanced with an ability to provide opportunity, challenge and encouragement against a backdrop of empathy, humanity and authenticity. This provides the context for 'holding the space' of Recovery. In her experience of leading organisational change towards a Recovery orientation Anne Markwick suggests that this process parallels that required of practitioners. In order to develop Recovery orientated practitioners and organisations we need to be able to 'hold the professional space' walking the walk of Recovery at all levels.

Yaara Zisman-Ilani and Orit Karnieli-Miller
From theory to practice: facilitating shared decision-making in psychiatric hospitals

SDM is an important theoretical model aimed to facilitate patient-centred care and involvement. While mental health services have been increasingly interested in SDM, its actual dissemination has been challenging. The purpose of the present study was to test the impact of an intervention which was developed to assist practitioners apply SDM principals within the context of psychiatric hospitals. *Method*
Two groups of psychiatric patients and their practitioners were compared; one was the control group (Treatment as Usual) and the other was the SDM group (in which practitioners worked with their patients using structured SDM intervention). This SDM intervention combines elements of motivational interviewing, positive psychology, coaching and psychoeducation. It also includes a computerized interactive options grid for comparing rehabilitation options.
Results
Our findings indicate that practitioners in both groups (control and SDM) reported high levels of SDM, but their patients reported an opposite picture. Patients in the SDM group reported high level of SDM when working with their practitioners, while patients in the control group reported significantly lower scores of SDM.
Conclusion
Implementation of a structured SDM intervention in psychiatric hospitals helps minimize the gap between theory and practice with regards to SDM by helping practitioners in the operational aspects of practicing SDM real-time.

Session 3.2 System transformation (Empowerment room)
Symposium - Third wave of implementing a Recovery orientated Approach in the City of Aarhus

Soeren Frost and Mette Svarre
Third wave of implementing a recovery orientated approach in the city of Aarhus – engaging users in the implementation process and in measuring personal outcomes

This Abstract is a part of a symposium and is considered as an introduction to the following abstracts: 1) Involvement of service users in reformulating the value based foundation 2) Involvement of service users in Homeless shelters 3) Screening of recovery indicators at an organizational level 4) Performance measurement and recovery orientation.
Since 2006, the City of Aarhus has strived to implement recovery orientation as the fundamental value based approach for the delivery of services for its citizens with psycho-social disabilities. Our experience is that there is not one method or concept that can guarantee system transformation towards recovery. A successful development of services that supports recovery and wellbeing therefore implies complex interventions where the nuances in our professional practice match the needs of the people receiving our services. After the first years of focusing on establishing what would constitute a recovery oriented practice (our first wave of implementation) and here after systematically training all staff (second wave of implementation), we have reached the third wave of implementing a Recovery orientated Approach. This wave focuses on two dimensions: 1) Further engagement of people with psycho-social disabilities in the implementation process bringing out the knowledge of recovery to clients and inviting them to participate in securing that the

services in Aarhus is supporting their individual way to recovery 2) Documenting effectiveness of the recovery oriented practice and interventions both on an individual level and in organizations. In the symposium, we will present how we have worked with the third wave of implementing a recovery orientated approach focusing on these two dimensions. Our aim is to offer researchers and practitioners rich practical insight into how they unfold.

Kurt Kyed and Ole Langballe
Involvement of service users in reformulating the value based foundation

As a part of the third wave the organization has systematically been working with enhancing the dialogue between staff and users and establishing a common language on the objections and trajectories of recovery. A group of system users took the initiative to reformulate the recovery values in order to establish a common understanding of the values behind a recovery orientated approach. The work has been shared with the both professionals and service users in the organization (850 professionals and 3500 service users) and has caused a growing engagement amongst the service users.
Method
Presentation of the work with involving service users and hence enhancing a growing engagement and commitment in the Service User group. Service Users will participate in the presentation and bring in their experiences.
Results
Providing the participants insight to how service users can be involved in and add value to the implementation process resulting in a growing commitment
Discussion
In the light of the described experiences to discuss the possibilities involving service users in the system transformation towards recovery.

Jakob May
Involvement of service users in homeless shelters

Centre for Homelessness and Specialized Efforts (CHSE) consists of two different shelters that provide social services towards homeless citizens. CHSE offers 120 rooms as temporary stays, and is furthermore running two permanent accommodations with 22 apartments based on ordinary legislation. CHSE works with a Recovery oriented valued based approach on all levels ranging from the individual to the organizational level. Central is the respect and understanding of the service users own perspectives and the involvement of service users on all levels. Involvement on an individual level is based on the social workers ability to involve the service user in all phases of the rehabilitation process from the initial ASI-shelter screening to the planning, support and evaluation of the service. The Service user is for example involved when the rehabilitation plan is discussed and/or when new decisions are made. The professional approach is based on the CARe methodology,- communication skills and coaching technologies. Involvement on an organizational level is based partly on Bindex technology and interviewing, and partly on recovery screenings, that identifies where CHSE can improve and strengthen in regards to aligning with the recovery values and supporting the service users' road to recovery. CHSE is for example working with how to support service user meetings and the topics that service users find important in regards to transforming the organization towards recovery.
Method
Presentation of the work with enhancing the involvement of service users in shelters for homeless on an individual and organizational level.

Discussion
Discussing the challenges and possibilities in involving service users of homeless shelters on an individual and organizational level

Runa Bjorn and Peter Boldsen
Screening of recovery indicators at an organizational level – do our service providers facilitate recovery?

We will present our experiences with developing a tool for screening the degree of recovery orientation among our providers of social psychiatric services at an organizational level. The first part of the screening is an evaluation of the organizational status of recovery orientation measured by questionnaires to service users, staff and managers, analysis of the quality of the local dialogue between service users and staff and observations in the organization and within the physical environment. The second part of the screening is a systematic dialogue with service users, staff and managers involved in order to qualify and discuss our findings resulting in recommendations of how to enhance the focus on recovery in the local practice. We will present: *Our screening tool and the indicators it is based on 'How the service provider and service users experience the screening process 'How the results of the screening is used in the organization that is the object of the screening and how the screenings can provide useful information for the senior management. So far the screening tool has been applied in 20 organizations in Denmark. The Department of Social Psychiatry of Aarhus has decided to screen all its service providers every two years in the years to come, and to further develop the tool to be able to screen whether the exercise of visitation authority is based on the recovery values and supports the users' road to recovery.
Method
A presentation of the screening tool and process, followed by discussions with the participants in the symposium.
Results
Providing the participants with inspiration as to how implementation of a recovery oriented practice can be underpinned by documentation and local developmental processes in which the users of social psychiatric services play a major role.
Discussion/Conclusion
In the symposium, we will invite the participants to discuss our findings and reflect on whether this way of organizational screenings could be applied in their organizations.

Malte Pihl
Performance measurement and recovery orientation

Performance measurement, performance management and recovery orientation. Sounds in-compatible, doesn't it? We don't think so. We document performance in various ways in different areas of our social services, but we also do it in a recovery orientated way. That is possible because we always keep the service user and the individual process in focus. In the city of Aarhus we have great experiences with using performance measurement in ways that supports the processes of individual recovery. We will present two very different concepts: A concept that we have developed in Aarhus 'Performance documentation' and a version of the European version of 'The Addiction Severity Index' which we have adapted to fit to the services provided to users of our shelters for home-less people. As a way of supporting the individual plan and helping service users setting individual goals the City of Aarhus have developed a Performance documentation tool for evaluating individual progress towards social or full recovery. The tool is measuring individual progress on dimensions

pointed out by service users as being important for individual recovery. The measurement is built on self-evaluation by the service user and a scoring by the staff in a close dialogue. At an individual level Performance measurement is a great tool to visualize the progress towards recovery and hence get information about where to strengthen the rehabilitation. Furthermore Performance measurement provides the top management and the political levels with information on whether or not the services provided deliver the desired and expected results. On one hand it allows the organization to enhance the services that are doing really well. On the other hand it provides the organization with the opportunity to initiate quality development initiatives for the efforts that are not doing as well as expected. This is also vital knowledge in regards to the development of the employee group's qualifications.
Method
A presentation and discussion about the use of performance measurement for strengthening recovery orientated rehabilitation
Results
Providing inspiration to participants as to how we can develop assessment tools that measure outcome and progress towards recovery

Chris Collins
Social housing in mental health: impact of anti-social behaviour on service users

I'd like to discuss more fluid ways in which agencies such as social housing, mental health care providers and possibly local police could work together in the interest of tenants who have mental health issues. I myself was subject to anti-social harassment and found that the path for achieving things was achieved on my own and felt there could be more close ties existing that are fluid and workable. This would apply to allocations in housing and avoiding placing ex-offenders with behavioural issues next door to people with mental health problems and how this issue could be changed with suggestions of implementation. I'm a governor at SLAM and I represent service users but much of my thinking is due to personal 'lived' experience so my views are grass roots. Many single people with mental issues get bullied on their estates and this becomes another but unknown factor to social inclusion.

Session 3.3 Relationships that support recovery (Comm-unity care room)

Kamilla Hasager Jensen, Britt Reuter Morthorst, Per B. Vendsborg, Merete Nordentoft
Evaluation of the mental health first aid training course in a Danish context

Previous studies show a high and growing prevalence of mental disorders in the population in general (1). One in five of the Danish population, will in any given year experience symptoms related to a mental disorder (2). The Mental Health First Aid concept (MHFA) was founded in 2000 in Australia by Kirchener and Jorm, in order to provide the population with mental health first aid skills. The aim of the concept is, through an educational course, to increase the mental health literacy of the public by increasing knowledge, reduce stigma and initiate supportive actions leading to professional help. Though promising results from both Swedish and Australian trails, further replication is needed, hence this study investigates the effect of MHFA as an educative intervention offered a Danish population.
Method
The design is a randomized trial, in which 500 participants will be allocated to either the

intervention group or the control group. The control group will attend the course six months later, hence waiting list design. From fall 2013 to spring 2014 participants will be educated 'First Aiders' following a manualized, two days MHFA course. All the participants will answer a questionnaire at base-line and at 6 months follow-up. The questionnaires in a Danish version have been validated in previous trails. The trial will be complemented by a qualitative study, in which focus groups will be carried out. Additionally, participant observation and a number of semi-structured interviews will be conducted with selected participants and people, who have experienced receiving help by the newly educated first aid helpers.
Results and Discussion
Available in 2015

Glinnis Goldring, Kate Hefferon, Tim Lomus
Enabling recovery in a structured hope programme

A qualitative study that explored motivations and experiences of substance-misuse clients who participated in a: Structured Hope and Recovery Positive Psychological intervention b: Responses were analysed using Thematic Analysis (TA). The study aimed to evaluate whether the intervention enabled the personal and clinical recovery for individuals accessing treatment for addiction.
Method
The study was conducted at a community substance misuse team (CSMT) hosted by SLAM NHS in London. The academic component was supervised by Dr Kate Hefferon at University of East London. Implementation of the project was overseen by the service psychologist. The intervention was implemented by a qualified clinical nurse undertaken as part of the requirements of an MSc qualification in Applied PP. Participants were clients of the CSMT engaged in treatment at the time of the trial, split into 2 groups:

- Group 1 - the Hope intervention completed in conjunction with Treatment as Usual (TAU) (8 participants)
- Group 2 – a matched compared controlled group receiving TAU and completing questionnaires only (8 participants).

The composition was male and female with drug and/or alcohol dependency, aged over 18, with no significant differences between individuals.
Results
Pre-motivation A results yielded three themes and various subthemes:

- Attitude towards treatment, Quality of life, Reasons for engaging

Post-experience TA results yielded three themes and various subthemes

- Hope programme ,Positive focus ,Empowerment

Discussion
This study gained much positive feedback from participants. The intervention is the first of its kind implemented in an addiction treatment setting. Resnick & Rosenheck (2006) discuss synergies between PP and 'the recovery movement': one, focused on enhancing the lives of the well, empirically based, defining 'the good life'; the other a grass roots movement heavy on concepts like empowerment, where the severely mentally-ill are controlling their own destinies. The two movements are complimentary. The author believes that PP can prove beneficial in front line healthcare settings whereby professionals seek to effectively support the substance-misusing population. Personal recovery and positive psychological principles overlap. Recommendations are for further positive psychological research to be carried out within substance-misuse treatment settings.

Helle Stentoft Dalum, Lene Falgaard Eplov, Inge Kryger Pedersen, Merete Nordentoft
Illness Management and Recovery (IMR): a randomized trial and a qualitative study to investigate effectiveness of the IMR program

Illness Management and Recovery (IMR) is a an educational program founded in the principal of recovery with weekly sessions dealing with the themes of recovery strategies, managing symptoms, managing relapse, and gaining a healthy life style. It is based on a recovery-oriented approach and the aim is to help people with severe mental illnesses to set goals for their lives and gain illness self-management skills and thereby contribute to their own recovery-process.
Method
The aim is to evaluate the effect of Illness Management and Recovery (IMR) in Denmark in two sub-projects. 1) A randomised controlled trial to evaluate the effect of IMR in the group format in Danish community mental health centres. 200 patients diagnosed with schizophrenia or bipolar disorder will be included and are randomised to either IMR and treatment as usual or treatment as usual alone. 2) A qualitative study to investigate how the recovery-oriented approach is reflected in practitioners facilitating the IMR program.
Results
We will present the preliminary results at the conference Introduction Illness Management and Recovery (IMR) is a an educational program founded in the principal of recovery with weekly sessions dealing with the themes of recovery strategies, managing symptoms, managing relapse, and gaining a healthy life style. It is based on a recovery-oriented approach and the aim is to help people with severe mental illnesses to set goals for their lives and gain illness self-management skills and thereby contribute to their own recovery-process.
Discussion
If IMR shown to be effective in this trial, it is likely IMR will have wide implications for future interdisciplinary treatment for people with severe mental illness and will spread to other psychiatric setting in Denmark.

Jerry Tew, John Larsen, Sarah Hamilton
Can personal budgets help to bring about a recovery 'mindset' in service users' relationships with practitioners?

At the heart of recovery are relationships that enable people to reclaim control over their lives - as part of rediscovering meaning and purpose in life and rebuilding an agentic sense of self. This implies a shift to user-led or co-productive relationships between practitioners and service users. On the face of it, personal budgets may provide a basis for achieving this, with the process of exercising choice through having a personal budget potentially contributing to a recovery 'mindset'. However, there can be confusion as to whether the purpose of personal budgets is to enable long term support, or progress towards recovery. A recent national study (the PEOPLE study) provides insights into whether and how receiving a personal budget may contribute to more recovery oriented working relationships between service users and practitioners.
Methods
In-depth qualitative interviews were undertaken with service users with serious mental health difficulties with experience of personal budgets, and their care co-ordinators.
Results
While few service users and care coordinators made an explicit link between accessing personal budgets and working towards recovery, this could nevertheless create a useful

discursive space for discussing goals and aspirations 'outside the box' with practitioners working alongside service users to identify their strengths and interests. A small number of service users seized the opportunity to take control and use the allocation to help them to become independent of mental health services. However, in other instances, service users were reluctant to assume control or sought to use the budget as a way of securing a long term position of being 'looked after'.
Discussion
On their own, the introduction of personal budgets is not sufficient to bring about more co-productive and recovery oriented relationships between service users and practitioners. However, they do provide a concrete mechanism which can enable a shift in this direction.

Lisa Korsbek, Esben Sandvik Tønder, Lone Petersen
Disruptive innovations – system transformation through decision aids

Two things are essential in a recovery oriented practice: 1) that the central model for decision is shared decision making, and 2) that peer support is an integral part of the way we organize practice. In the Mental Health Care of the Capital Region of Denmark we are in a process of implementing shared decision making through an app-based decision aid with peer supporting to maximize people's opportunity to take active roles in decisions about their treatment.
Methods
The app is developed in collaboration with a company that specializes in the development of modern technology to the field of mental vulnerability. The testing is done in a pilot with both hospitalized patients in a rehabilitation unit and patients in an assertive community treatment centre. Training and support are done through the project's support team in the form of employees of people with lived experiences of mental illness. Using personal experience the support team supports the consumer directly in preparing for influence and empowerment in the shared decision making process.
Results
As part of preparing the implementation of the decision aid throughout the Mental Health Care in the Capital Region we intend to do quantitative and qualitative evaluation with semi-structured interviews on the importance of using the tool for the consumers' experience of involvement and influence and for consumer and staff's assessment of empowerment.
Discussion
The app is part of the growing movement toward consumer empowerment that means that people can be involved in decisions that move beyond just taking medications to using them as part of their recovery. Furthermore, we see the app as a disruptive innovation that by affecting the very core of the dialogue between therapists and patients can contribute to organizational changes and thus to system transformation.

Olga Shek
Empowerment and user participation in post-soviet mental health services: reflections from the soviet past?

The major transformations in Russian society after the collapse of the Soviet Union had an impact on mental health policy in the country as well as the ideologies regarding mental health in general. As part of this, Post-Soviet Russia has initiated reforms of mental health system, which was earlier sharply criticised for restriction of patients' rights and ineffectiveness. In this paper I describe some challenges for implementing approaches that support recovery in Post-Soviet mental health services, focusing on such aspects as

empowerment and user participation.
Method
The research material consists of mental health policy documents, interviews of professionals working in mental health services as well as interviews with people with experiences of mental illness. The study uses qualitative research methods such as qualitative content analysis and critical discourse analysis.
Results
The preliminary results of the research demonstrate that neither policy documents nor mental health professionals recognise the knowledge of service users as a basis for developing of services. The people with experiences of mental illness reported that they are regarded mostly as passive recipients then active participants of the recovery process. However mental health service users have many more rights nowadays than in the Soviet period. This can be considered a step away from paternalism. The recently available psychotherapeutic and psychological methods, which increase self-confidence and personal autonomy of people with experiences of mental illness, are an important resource for their empowerment.
Discussion
Socio-political background is considered an important explanatory factor in understanding why users' empowerment and participation in former socialist mental health services are underdeveloped. In my talk I will discuss how this mediating effects of the past can influence the trajectory of the reforms in Post-Soviet mental health system.

Session 3.4 Keeping well in daily life (Hoping for more room)

Ian Porter,Vanessa Pinfold, Daryl Sweet, Cath Quinn
Critical reflections on role of home in supporting recovery for people with severe mental illness

Increasing numbers of people with severe mental illness (SMI) are living without specialist mental health support. Their recovery journeys are shaped through connections to a wide variety of resources within communities: personal, neighbourhood, interest - or work - focused, friendship and family orientated. We have explored the social resources, meaningful activities and places of people with SMI and in this paper reflect on the role of home life in recovery.
Method
41 semi-structured interviews were conducted, purposively sampled from 150 participants with SMI within a mixed methods study that explored an individual's connections to people, places and activities in order to map their personal network. Thematic analysis was carried out to critically scrutinise influences including active agency and the role of home place.
Results
We identified building blocks' that provided individuals with a basis upon which to build person centred goals for managing wellbeing, including both physical and mental health needs. One place that illustrated the potential for active change was home. Intersected within narratives of illness, and fluctuating health, home was shown as an important base to develop meaningful routines that enhance wellbeing: a social place, a positive space for building self-identify and exerting control. It was also revealed as a place fraught with negative associations and relationships, reflecting a sense of one's life in stasis or decline, representing a cycle of isolation and feelings of being overwhelmed or lacking control.
Discussion
Home relates to more than just shelter and basic needs; it is a reference point in people's

lives and has significance associated with identity and sense of self, wellness and mental illness, relationships and experiences past or present. Identifying the building blocks' of recovery for many of those interviewed involved home place. We recommend further research is required to develop home centred interventions to support recovery.

Elizabeth Huges, Milton Wainberg, Francine Cournos, Veronica Pinho
Mental illness stigma and sexual health

Mental illness stigma has a dramatic effect on the lives of people receiving care for mental health disorders; however, its impact on sexual health and sexual behavior isn't clear. Modified labeling theory suggests that stigma influences behavior both through social environmental and social psychological processes. We examined the dynamics of mental illness-related stigma and how it shapes sexual self-concepts and behaviors of adults receiving psychiatric care.
Method
Between June 2007 and November 2009, 3,811 outpatients were screened at 4 community mental health clinics and 4 major psychiatric hospitals in Rio de Janeiro, Brazil. Among the 1348 participants who were sexually active in the last 3 months and therefore eligible to participate, 641 consented and completed the interview. Adapting Link and Phelan's theoretical model of mental illness stigma, we elicited from participants mental illness sexual stigma experiences. Participants also completed the Sexual Risk Behavior Assessment Schedule about their sexual relationships and risk behaviors.
Results
Participants were female (58.0%), with a mean age of 42.8 years, and described themselves as multiracial (47.7%), white (32.8%), or black (19.5%). Most participants were married/in a long-term relationship (46.8%) or single (35.1%). The majority of participants had diagnoses consistent with severe mental illness (SMI): schizophrenia (32.8%); bipolar disorder (21.1%); depression with psychosis (10.1%); psychosis NOS (3.4%); or schizoaffective disorder (3.1%). Results suggest that stigma operates though three major pathways: broad societal attitudes, structural constraints and discrimination, and experiences of direct individual discrimination. Effects of stigma on sexual self-concepts and sexual relationships and behaviors were mediated by certain psychiatric symptoms, but the social-psychological processes domain which reflects internalized stigma related to sexual self and sexuality influenced the type of sexual activity reported by participants.
Discussion
Sexuality of those receiving care for mental health disorders is an important but largely overlooked factor in recovery. Our findings highlight opportunities for stigma amelioration.

Bror Just Andersen
Practice in the C-Flex team in Baerum

When establishing assertive outreach services in Norway the answer has largely been establishing ACT-team or similar with diagnosis based admission criteria. The risk is however that one creates new errors in the patients flow and new groups falling outside treatment, relative to the goals. In Baerum we turned it bit upside down, and the 01.01.12 we established a collaborative team where the main admission criteria is poor or total lack of connection to services. Diagnosis is not used as the basis for admission, and age is immaterial. The project has developed a flexible, functional, committed collaboration model for primary and secondary mental health and substance abuse services; the C-Flex model. We have created an interdisciplinary collaboration team of employees in fractional positions

also still staying in their initial positions.
Method
The objectives for the intervention is that people with prolonged, severe mental illness and / or severe substance abuse disorder and poor or lack of connection to public services gets unified and coherent treatment and services. The purpose of the evaluation is to examine the effect of the teams work according to the C-Flex model has on the target group's functioning, quality of life, substance abuse and mental health. We seek to answer these questions through mapping, using validated measuring instruments and through reviews of changes in known risk and protective factors. It is an intervention study with cohort design. Registration of outcome variables are when possible be at admission to treatment (t0), after 3-6 months (t1) and after 12 months.
Results
The inclusion of patients started 10.2012. The evaluation has much parallelism to the national evaluation of the ACT-teams in Norway. We therefore have an agreement about using the other's data as control group. My presentation will be development of C-Flex, experiences, methodical approach, preliminary results.

Oona Lassenius, Maria Arman, Anne Söderlund, Lena Wiklund-Gustin
Being physically active: a bodily anchorage on the journey toward recovery

Suffering from mental ill-health is not only a psychiatric distress, but also entails an increased risk of physical ill-health. Despite this, the body is still relatively invisible in mental health care. However, there is a growing field of research about the significant relationship between physical activity and mental health but there is still more to be learned about the subjective experiences of bodily movement. This knowledge is of importance in order to improve the ability of persons with mental ill-health to become more physically active. The aim for this presented research was to illuminate lived experiences of being physically active among persons with mental ill-health.
Method
With a qualitative design, interviews were conducted with fourteen persons who were community mental health care users in a community in Sweden. For the analysis of narratives, a phenomenological hermeneutical method for interpretation was used.
Results
Moving one’s body through physical activity rendered an opportunity to connect to a sense of ‘being-in-the-world’, for experiencing meaning and could facilitate a reconnection with an inner force of life. But it could also involve challenging experiences of an inhibiting body, feelings of shame, and lack of companionship as impediments to being physically active. Whether experiences were of enabling or limiting denomination, they all conveyed existential dimensions.
Discussion
The enabling, as well as limiting, experiences can be used as clinical indicators for finding what can strengthen the inner drive of the individual for being physically active. Furthermore, the findings underline that physical activity does not only promote physical health, but also reinforces the ability of the person for recovering life. Hence, the main message is the importance of focusing recovery in mental ill-health in a holistic perspective, which also conveys an emphasizing of the fact that recovery might need a bodily anchorage.

Calgan Zeynep and YegenoÄŸlu Selen
Pharmacists’ role in personal recovery and wellbeing: what do the published studies say in PubMed

The term of ‘recovery’ which take recovery process as ‘recovering a life worth living’ beyond ‘recovering from the illness’ opens a new way for health professionals in order to promote public health. In accordance, pharmacists’ role in public health is regarded as not only counselling patients on medicines but also contributing to disease prevention and health promotion. At this point, ‘personal recovery’ requires pharmacists to be an active part of the healing process. However, pharmacists’ role in mental health focuses on pharmaceutical care in practice. In this context, it is aimed in this study to explore the literature in order to identify pharmacists’ role in personal recovery and wellbeing.

Method

Literature search was conducted in PubMed database in order to determine mental health pharmacy services. Along with the MeSH terms ‘pharmacists’, ‘pharmacies’ and ‘community pharmacy services’; ‘recovery’, ‘mental health’, ‘psychological wellbeing’ and ‘community mental health services’ terms were used.

Results

When pharmacists’ role in mental health services is assessed in terms of personal recovery and wellbeing, it is seen that patient education about their medications and monitoring of drug treatment and compliance are especially addressed in Pubmed studies within the scope of mental health pharmacy services. Thus, it can be stated that pharmacists’ role in personal recovery and wellbeing is limited to the medication therapy of mentally ill patients and their carers similar to the pharmacy practice.

Discussion

According to the literature in PubMed, pharmacists’ role in personal recovery and wellbeing is limited to the pharmaceutical care practices for mental health. Although pharmacists’ role in pharmaceutical care maintains its importance, new roles for pharmacists concerning mental health can contribute to the healthy way of living of their customers. In this regard, it is of importance to raise awareness regarding broader meaning of personal recovery among mental health professionals including pharmacists in order to improve mental health services.

Vicky Stergiopoulos and Suzanne Zerger

Coping in context: experiences of homeless people with mental illness from racialized groups

Marginalized groups, such as homeless, ethnoracial persons and immigrants, are more likely than others to experience chronic stressors. Yet even though individuals frequently belong to more than one of these groups, little is known about whether or how these multiple identities affect their coping strategies and mental health.

Method

We used an intersectionality framework to explore this question because it recognizes that effects of multiple identifies are complex and non-additive. The 36 individuals participating in this qualitative study in Toronto, Ontario, identified with multiple marginalized groups; all were non-White, were experiencing homelessness and mental illness, and a majority were newcomers to Canada.

Results

Grounded theory analysis revealed several dominant stressors characterizing their social environments: powerlessness and worthlessness, related to homelessness and caused or exacerbated by mental health problems, and racial discrimination and cultural disconnectedness, related to ethnoracial and/or immigration status. We examine contextual effects on their three most common coping strategies: socializing, finding an ‘anchor’, and engaging in meaningful activities. *Discussion*

By overtly drawing the link between specific contextual challenges and their social location, and articulating their effects on coping, methods for bolstering coping attempts are more readily understood and exposed.

Parallel Session 4 – 9.50am Tuesday 3rd June

Session 4.1 System transformation (ReThink room)
Symposium: Shifting to recovery orientation together, across public sector mental health services This symposium presents five initiatives to advance recovery orientation (RO) in diverse elements of the public mental health sector. These presentations explore RO activity, organizational collaborations and vital leaders' relationships, across the fields of action.
Bridget Hamilton **Recovery orientation in policy agenda**
We outline the Victorian Framework for Recovery Oriented Practice (DoH, 2011), and detail its collaborative production, incorporating perspectives of consumers, practitioners and senior managers. The Framework is pitched to clinical and support services.
Bridget Hamilton **Recovery orientation in the Strengths Model in a clinical setting**
A narrative evaluation of the Strengths Model gathered consumers' experiences of the service. It showed consumers value the quality relationship and practical focus within Strengths. The initiative illustrates the Framework policy and co-production methods of research.
Bridget Hamilton **Recovery orientation in consumer-led education & research**
The Consumer Academic teaches a compulsory consumer perspective subject for postgraduate students and leads research activity across the sector. The University teaching shapes clinicians such as mental health nurses and draws on the Framework policy as a resource.
Cath Roper **Recovery orientation in non-government support services**
The first Recovery College in Australia will deliver education through a partnership between a non-government support service and a clinical mental health service in metropolitan Melbourne. The for the College was developed through relationships with Recovery Colleges in the UK and is supported by government and philanthropic partners here in Australia.
Sarah Pollock **Recovery orientation in clinical service management**

The Director of Consumer and Carer Relations leads many recovery oriented initiatives across a major clinical service, and contributes to everyday governance and operational management in ways that shift the traditional clinical culture.

Discussion
The symposium concludes with a panel discussion to highlight differences, intersections and collaborations, across these RO initiatives.

Session 4.2 Relationships that support recovery (Empowerment room)

Agnete Neidel
Partnerships for inclusion and citizenship – community mapping: a way forward?

International research has shown substantial evidence, that social networks, participation and access to a valued role in society and communities. To move this agenda forward, 10 different communities across Denmark have recently engaged in mutual partnerships between Mental Health Services and various community agents and organizations. The partnerships aim to create new, innovative practices, supporting inclusion and social capital building for and with people with mental health problems. Simultaneously, the partnership work towards community development and development of the connectivity between services and local communities. The aim of the collaborative process is to strengthen community opportunities for the people involved in services, and to work against stigma and isolation in secluded service-based communities.
Methods
The current study will focus on a method applied in the 10 local partnerships, mapping relevant social resources and networks, in the initial process of forming the partnership as well as the shared interventions and initiatives in the community. The aim is to work systematically with creating shared knowledge of the community's resources and challenges, and to include as different perspectives in the development of a collaborative, inclusive community practice. Qualitative analysis of the community mappings as well as of participants' reflections on using the method will be conducted. *Results*
The oral presentation will be presenting the first results of the use of community mappings as a method to build partnerships and develop new practices. A brief analyses of the results and experiences from a selection of the local partnerships. Analysis will address the question of the method's effectiveness in strengthening the partnership, creating new knowledge on social networks and resources in the community and opening up new scopes of action toward an inclusive community. *Discussion*
Creating inclusive communities and supporting access to participation and positive social roles require new ways of moving forward and new connections between services and community life. Methods for change need to be developed and systematically evaluated, in order to support the changes required.

Martin Webber, Meredith Newlin, David Morris
The connecting people intervention: findings of a quasi-experimental pilot study

The orientation of mental health services towards a recovery paradigm requires mental

health workers to engage with an individual's social network or community to enhance their relationships. However, there is little research evidence about effective approaches to enhancing an individual's social connections. This paper presents the findings of a multi-site pilot of the Connecting People Intervention (CPI) in England which provides an intervention framework and practice guidance for practitioners.

Method

The CPI was piloted in 14 agencies across England working with people with a mental health problem or a learning disability. A quasi-experimental study design was used where increased fidelity to the CPI was hypothesised to be correlated with increased social participation and well-being over a 9-month follow-up period for the 155 participants. Process data was collected through qualitative interviews with service users, practitioners and managers to understand how the intervention framework and practice guidance was implemented in each health or social care agency.

Results

Using the CPI to build social connections has had positive outcomes for participants, in spite of the mixed implementation of the CPI in agencies, for a variety of logistical and practice-related reasons. Findings from the pilot study and economic evaluation will be presented, including data on how individuals experience their relationships in the recovery process.

Discussion

Using both longitudinal quantitative data and findings from qualitative interviews can help to enhance our understanding about how to best enhance individuals' social connections. However, challenges in implementing interventions in resource-constrained agencies need to be overcome in order to improve outcomes and ensure mental health practice is as effective as possible. Conclusions will be drawn about how workers can best support the individuals they work with to develop their social relationships.

Bernard Pachoud and Inès de Pierrefeu

Why supported employment benefits from being a recovery-oriented practice

Return to work is not only one of the criterions of recovery, it is also one of the means of recovery for a number of reasons. Working confers a social identity as a professional, that helps to rid of the identity of a mentally ill person. At work, people feel recognised for their abilities and their contributions, which is a basis for self-esteem; they get a feeling of efficacy, which improves self-confidence. The question is whether and how this process should be supported? Is there a strong link between supporting work integration and promoting recovery?

Method

A review of the scientific literature on vocational rehabilitation, particularly on supported employment, makes it possible to outline how and why these practices are recovery oriented. Our own empirical researches on support toward employment provide convergent observations.

Results

A number of comparative studies have shown that supported employment is the most efficient way to help people with a severe mental illness to get (and to keep) a job. One of the main differences between supported employment and traditional practices in helping these people into employment is the relational involvement - in the supported employment model - of one person, the job coach, instead of a series of experts. It has also been shown that, among supported employment practices, the most efficient ones depend primarily on the competences of the job coach, its ability to negotiate with the employers, and, most importantly, to build a strong, uninterrupted and long term relationship, and a work alliance, with the person looking for work.

Discussion

We will discuss arguments showing that the more the vocational support is recovery

oriented, the more efficient it turns out to be in terms of vocational outcome.

Session 4.3 Relationships that support recovery (Partnership room)

Jessica Holley, Steve Gillard, Mary Chambers
The impact of risk management practice upon the implementation of recovery-oriented care

Recovery-oriented care has become a guiding principle embedded within mental health policies and practice. Encouraging service users to take risks, also known as positive risk taking, is thought to support the recovery approach. Research suggests there is a lack of differentiation between positive risk taking and the risks which need to be managed in routine mental health services. This qualitative study adopted a critical discourse analysis methodology in order to explore how risk management practice impacts upon the implementation of recovery-oriented care within community mental health services.
Method
Semi-structured interviews using vignettes were conducted with 8 mental health worker and service user dyads. Using a combination of framework and grounded analysis techniques the data were organised into categories illustrating whether the management of risk and promotion of recovery were complementary, conflicting or complex processes.
Results
Four themes arose: 1) perceived responsibility for risk and recovery; 2) risk communication and shared-decision making; 3) opportunities for social inclusion and attitudes to risk; 4) mental health workers' risk-averse working environment.
Discussion
Mental health workers described how they would idealistically use a positive risk taking approach in support of recovery-oriented care. In practice, this is restricted by a risk-averse culture embedded within mental health services. A hybrid discourse of risk and recovery emerges where mental health workers remain responsible for assessing service users' mental capacity and managing risk of relapse. Mental health workers set conditions for recovery and service users comply with these conditions to gain responsibility for recovery. There is a need to make risk management practice more explicit in recovery policies and training to help mental health workers balance positive risk taking and risk management practice. Service users and mental health workers should be trained how to openly communicate risk with each other in order to share responsibility for managing risk in recovery.

Dr Yael Bankirer, Inbar Adler Ben Dor
Undermining the narrow concept of motherhood: a consciousness-raising group therapy of women who are both mothers and coping with mental disability

The majority of contemporary research on parenthood among women who experience severe mental illness, emphasize the ways in which the mental illness diminishes a woman's parenting capacity. This approach is rooted in both the patriarchal model of motherhood and in a narrow, one-dimensional, medical approach to mental illness. Even though feminist theoretical discourse has been deconstructing motherhood, women presenting with mental illness do not have the privilege to enjoy such increasing social tolerance. The narrow model of motherhood is reflected in a public stigma that consists of an automated critical priori

assumption, that mental illness reduces a woman's ability to function as a parent.
Method
For two years, we have worked with a group of women holding these identities. The women met once a week in a unique rehabilitation centre in Israel. They came from different backgrounds: different cultures and religions, different financial status, different ages and presented with different psychiatric diagnoses.
Result and Discussion
In spite of the differences, the women in the group shared in common the cultural meaning of holding these identities. Their constant self-judgment and scrutiny of everyday life reflects the totality of both being a mother under patriarchal culture and coping with mental illness in a stigmatic society. For them, the 'bad mother' image was inherently connected with that of the 'ill mother' and hence they experienced their illness as a constant threat to their functioning as mothers. During the group process, the women developed a critical perspective on the social totality of both identities, and were empowered by learning to trust their experience and knowledge. Gradually, they developed a critical consciousness and while breaking down the narrow model of motherhood, the group challenged the cultural conceptions of mental illness as well.

Oona Lassenius, Maria Arman, Anne Söderlund, Lena Wiklund-Gustin
Motivating to physical activity – a way of being, relating and understanding

Despite strong evidence for the positive relationship between physical activity and mental health, physical activity is still used far too little to promote health in mental health care. It is argued that lack of motivation is one barrier for persons with mental ill-health to be physically active and limited knowledge among caregivers is also considered to be an impediment for this. Therefore, the aim of this study was to explore how caregivers experience motivating persons with mental ill-health to physical activity.
Method
With a qualitative design, interviews were conducted with fourteen caregivers working in community mental health care services in Sweden about their experiences of motivating persons with mental ill-health to be physically active. Data was analysed using a phenomenological-hermeneutical approach. *Results*
The interpreted meaning of motivating to physical activity was expressed as a dynamic way of being, relating and understanding. This dynamic co-creation of motivation came to life through sharing experiences in movement and by this, affecting each other's life-worlds. Internalized understanding about the specific conditions of mental ill-health could render meaning in the sometimes challenging motivational work. Hence, motivation was expressed as something to be lived or in other words - a way of being and being together, rather than just doing. This reciprocity can be considered a prerequisite for bringing about motivation and is also what supports personal recovery.
Discussion
Limited knowledge among caregivers may well be one impediment for the enabling of physical activity, but knowledge also requires a deeper understanding based on a genuine belief in the person's ability to evolve. Further, the problem with lack of motivation to physical activity is likely not just the case with persons with mental ill-health. Also caregivers have to reflect upon their own motivation to motivate, in order to respond to the relational aspects of motivation and recovery.

Session 4.4 Keeping well in daily life (Comm-unity care room)

Cath Quinn, Sue Forber, Dan Marshall, Richard Byng
Producing a booklet on talking therapies and ideas to help yourself

The Talking Therapies Involvement Group (TTIG) included people with lived experience of mental health issues and IAPT (Improving Access to Psychological Therapies) services. Having contributed their experience based knowledge to an academic evaluation of south-west services, they decided to undertake their own work about the points at which the group identified people required support, but which services weren't commissioned to deliver.
Method
Four focus groups (19 participants) were conducted using a semi-structured topic guide. A TTIGer co-facilitated each focus group; academic researchers supported throughout. A deductive qualitative thematic analysis was undertaken to establish what sort of information people would have, and had, found helpful. A booklet was produced to communicate this information. Two mental health peer-support groups commented on the booklet to improve the design and content.
Results
The points at which people required additional support were from having asked for help until an initial appointment and after leaving an IAPT service or course of treatment. The main areas that people reported it would have been useful to have more information on were: 1) Mental illness, its' triggers and symptoms; 2) What Cognitive Behavioural Therapy (CBT) was and information about other treatments; 3) Ways in which people could help themselves. The primary result was the booklet produced, which included information on all of these areas, and other resources, as well as encouraging people to take an active part in their recovery.
Discussion
The TTIGers group have demonstrated sensitivity to gaps in the support provided by statutory services, based on their own experiences, and have provided a solution. In learning to keep well in their daily lives they have produced a resource to support others. Dissemination of the booklet is now being undertaken.

Helene Regle
Could the French practice of "Institutional Psychotherapy" be recovery oriented?

The "Institutional Psychotherapy" (Tosquelles, Oury) has oriented several French psychiatric services since the 50's and is still living in a few places. Although diverging from the recovery movement at least by its psychodynamic approach, this practice is nevertheless grounded in the fact that a daily work has to be done to avoid the pathogenic consequences of the encounter with any service of care. This constant reflexion shapes a praxis where carers and patients can meet as Subjects and where the resulting ambiance is of prime importance for the transformation of all.
Method
The specificities of this practice -experienced in a mutual help group and in the La Borde clinic- are analysed and discussed in regard with the preconisation for recovery-oriented services.
Results
Principal specificities of the & "Institutional Psychotherapy" are evoked, and particularly the way by which the status between all actors in presence are subverted ('ill' and 'staff' people

working together in everyday life of the clinic, suppression of hierarchy among staff people, instauration of joint decisional instances for the expanses, all together meetings'). An ambiance emerges from such an organisation, where the words of a few do not prevail over the ones of many. This free circulation of voices facilitates the initiatives of anyone, since it does paradoxically schedule the unforeseeable, which can be heard and supported by the collective.

Discussion

The concept of collective of the 'Institutional Psychotherapy' is aimed to have an effect on the double alienation - social and psychopathologic. It seems that this subversion of status, clearly distinct from a denial of the psychopathology, allows reaching mutual relationships desirable for promoting the auto-determination in recovery processes. This state of mind involves however a daily work which impregnates the place and the people, and which is not innate. We wonder in which conditions this practice could be transferred to other services.

Chris Griffiths
Recovery house 'sleep pack' initiative

Sleeping problems occur in most people with mental disorders. They can be a symptom of mental disorder and a contributing factor (NINDS, 2004; Nofzinger & Keshavan, 2002). During Christmas 2013 Rethink Mental Illness launched a 'Sleep Pack' initiative for people using their London based Recovery Houses. The goals were to improve sleep patterns and quality of sleep, and through this to improve wellbeing and reduce number of disturbances/ incidents at the houses.

Method

The Home Treatment Team refers people, who are in or have recently experienced a mental health crisis, to the Recovery Houses. Service users can come from the community or from a psychiatric hospital ward. The sample size is 300 and one of the Recovery Houses acts as a control. The Sleep Pack initiative has four elements to it: 1. on entry to the house staff engage with the service user in a discussion about their sleep and importance of sleep, 2. providing a sleep pack containing sleep aids and evidence based tips, 3. a sleep workshop delivered at the house, 4. staff asking service users during their stay how they are sleeping and reminding people to consider using the sleep aids and tips. Sociodemographic data, information on sleep (adapted version of Pittsburgh Sleep Quality Index [PSQI]) and wellbeing (Short Warwick Edinburgh Mental Wellbeing Scale [SWEMWBS]) are collected on entry and exit to the house. The number of disturbances/ incidents at the houses are also being recorded.

Results

The project is currently under way and will complete in April 2014. The full set of results will be presented.

Discussion

Discussion of the full set of results will be presented. The results will be used to consider further application and improvement of the Sleep Pack initiative and to produce a report and an academic article.

Session 4.5 CEDAR study meeting (Hoping for more room)

Open to CEDAR team members only

Parallel Session 5 – 11.50am Tuesday 3rd June

Session 5.1 SLAM Recovery College Launch (ReThink room)

Open to anyone.

Session 5.2 System transformation (Empowerment room)

Jackie Lawson, Phil Morgan, Paul Siebenthal
"Walking the walk": how NHS staff's own experience of trauma can shape recovery orientated culture

Recovery orientated practice requires NHS Staff to re-evaluate how they perform their roles and how they relate to those who access their services (SCMH 2010). Central to this is exploring the role of 'lived experience' and how staff's experience of trauma can be utilised to support recovery and encourage transformation of organisational culture. This presentation will pull together two pieces of work; a staff lived experience survey and the outcome of 3 focus groups; guidelines for NHS staff to disclose and utilise their lived experience.
Method
Two local service reviews; A survey of Mental Health employees, exploring lived experience of staff and 'them and us' culture and three focus groups with representatives from the NHS, people who access services and Professional Bodies to develop a document that explores how staff can safely share their lived experiences of trauma (which may or may not include mental health problems). *Results*
31% survey response rate (n=436), 52% stating they have lived experience mental health problems, 43% felt there was 'some' them and us culture. The majority focused on organisational culture being the main way to address staff emotional wellbeing. Focus groups acknowledged sharing lived experience is a complex process and there is no clear right way to do so. The guidance developed offers suggestions, along with questions to consider when sharing lived experience.
Discussion
The development of Recovery and emergence of peer workers, has led to members of NHS staff, stating, I've got lived experience. How do I use it? Some HAVE already used their experience, irrespective of whether their organisation or professional body condone it. Everyone has life experience and varying forms of expertise. Acknowledging a shared humanity supports recovery approaches and promotes necessary within-system transformation.

Clair Le Boutillier, Vanessa Lawrence, Mary Leamy, Mike Slade
Staff perspectives on supporting recovery

Recovery has come to mean living a life beyond illness, whether or not symptoms are present. A recovery orientation is policy in many countries, yet staff views on supporting recovery are under-researched. The study aimed to investigate what clinicians, team leaders and senior managers say they do to support recovery and to identify what they perceive as

barriers and facilitators associated with providing recovery-orientated support.
Method
Grounded theory methodology was used. Ten focus groups were conducted with multidisciplinary clinicians (n=34) and team leaders (n=31) from five Mental Health Trusts across England, followed by individual interviews with clinicians (n=18), team leaders (n=6) and senior managers (n=8). The developed theory was placed in broader context following a systematic review of existing literature. *Results*
The core category was Competing Priorities, with staff identifying conflicting demands across levels of the health system that influence how recovery support is implemented. Three sub-categories were: Business Model, Health Processes, and Staff Role Perception.
Discussion
System priorities influence how recovery-orientated practice is implemented, so efforts to transform services towards a recovery orientation require a whole-systems approach to develop shared beliefs about the core business of mental health services.

Lone Hellstrom, Lene Falgaard Eplov, Merete Nordentoft, Per Bech)
Early supported employment for patients with anxiety or an affective disorder

Anxiety and affective disorders can be disabling and significantly impact peoples' ability to work. In Denmark people with a mental disorder, and mainly non-psychotic disorders, represent a substantial and increasing part of those receiving disability pensions. Previous studies have indicated that Individual Placement and Support (IPS) has a positive effect on employment, when provided to people with severe mental illness. We have modified the IPS intervention, aiming at supporting people with recently diagnosed anxiety or affective disorders in regaining their ability to work and their return to work or education, without pre-vocational training, in a Danish context. The IPS-modified for mood and anxiety (IPS-MA) consists of individualized mentor support; coordination of activities; career counselling; help clarifying personal finances; and support in obtaining jobs, and keeping them. The aim is to investigate whether the IPS-MA has an effect on employment or education, when provided to people with recently diagnosed anxiety or affective disorders.
Method
The trial is a randomised, assessor-blinded, clinical trial of IPS-MA in addition to treatment as usual compared to solely treatment as usual for 324 participants diagnosed with anxiety or an affective disorder, living in the Capitol Region of Denmark. Primary outcome is competitive employment or education at 24 months. Level of symptoms, functioning and quality of life are secondary outcomes. Participants are followed-up 12 and 24 months after baseline.
Results
The trial is on-going, inclusion ended 31. January 2014. Preliminary results will be presented. Final results are expected 2016.
Discussion
If IPS-MA is shown to be superior to treatment as usual, a large number of disability pensions could probably be avoided and long-term sickness absences reduced; with major benefits to society and patients. This trial will add to the evidence of how best to support people's return to employment or education after a psychiatric disorder.

Bror Just Andersen
All inclusive – or not? ACT and FACT about practice, methods, and the effect-evaluation of C-Flex in Norway

When establishing assertive outreach services in Norway the answer has largely been establishing ACT-team or similar with diagnosis based admission criteria. The risk is however that one creates new errors in the patients flow and new groups falling outside treatment, relative to the goals. In Baerum we turned it bit upside down, and the 01.01.12 we established a collaborative team where the main admission criteria is poor or total lack of connection to services. Diagnosis is not used as the basis for admission, and age is immaterial. The project has developed a flexible, functional, committed collaboration model for primary and secondary mental health and substance abuse services; the C-Flex model. We have created an interdisciplinary collaboration team of employees in fractional positions also still staying in their initial positions.
Method
The objectives for the intervention is that people with prolonged, severe mental illness and / or severe substance abuse disorder and poor or lack of connection to public services gets unified and coherent treatment and services. The purpose of the evaluation is to examine the effect of the teams work according to the C-Flex model has on the target group's functioning, quality of life, substance abuse and mental health. We seek to answer these questions through mapping, using validated measuring instruments and through reviews of changes in known risk and protective factors. It is an intervention study with cohort design. Registration of outcome variables are when possible be at admission to treatment (t0), after 3-6 months (t1) and after 12 months.
Results
The inclusion of patients started 10.2012. The evaluation has much parallelism to the national evaluation of the ACT-teams in Norway. We therefore have an agreement about using the other's data as control group. My presentation will be development of C-Flex, experiences, methodical approach, preliminary results.

Monica Strand, Deede Gammon, Lillian Sofie Eng
eHealth and recovery – what are the potentials?

Empowering patients to take a more active role in managing their health through patient-centered collaborative care is desirable for therapeutic response, recovery and is considered as basic civil right. Overall there are essentials challenges regarding empowerment and collaborative care, such as; lack of user-centered collaboration between levels of care, user involvement and participation, and self-management support and effective ways to involve patients in the healthcare must be found. One of the solutions to these challenges could be interactive health communication applications. A practice-research team including service users, clinicians, IT-experts and researchers developed a pilot version of an online tool for assisted self-help in mental health care. During this pre-pilot phase we found our home in recovery as it reflects our intentions and hopes about the online tool called PsyConnect. The objective of the study is to explore and describe how such online tools could facilitate recovery-oriented health services.
Method
The online tool is being pilot tested in two communities, by 40 service users and their providers involved in different levels of mental health care. Qualitative interviews of service users and health professionals both in pairs/teams, individually and in groups will be conducted, and additionally the service users will answer a questionnaire about health and

recovery processes during the testing. The study is conducted in collaboration with a user consultant/co-researcher.
Results
The results will be continuously incorporated into iterative design processes. Together with preliminary findings the pre-pilot version of the tool will be presented at the conference.
Discussion
The tool itself will not change existing practice. The value of PsyConnect will be closely linked to organizational and cultural adaptations within clinical practices that are aligned with recovery thinking.

Session 5.3 Keeping well in daily life (Partnership room)

Bridget Hamilton, Tracy Beaton, Anna Love, Mark Davies
Transforming acute inpatient nursing practice – orienting to recovery

Inpatient psychiatric settings are fundamentally oriented to ensuring safety, minimising risk and addressing symptoms. The emphasis on staff responsibility and expertise in these matters can be at odds with consumers' necessary work toward their own recovery. Participatory evaluations and practice-change approaches can support the aim to re-orient practice towards recovery, with the focus on collaboration and empowerment. We report on process and outcomes for the approach taken in an acute mental health service Victoria, Australia to co-produce practice change.
Method
This service improvement initiative involves consumers, carers, nurses and other health staff from a mental health inpatient unit working collaboratively to identify 'touch points', or aspects of mental health nursing care where change could occur to impact positively on people's experience of acute care. Participants then jointly determine, enact and review interventions, to support the change. Impacts are captured through qualitative interviews, audit and routine patient outcome data.
Results
We describe the initiatives and preliminary outcomes of changes to the practices and orientation of the inpatient unit, from the perspective of consumers, carers and staff.
Discussion
People who use a particular mental health service can provide valuable input into what areas of the service delivery could be strengthened, based on personal experience. Resultant changes matter to consumers and attention is productively drawn to consumers' and carers' expertise. This improvement process helps staff to understand and engage more with consumers own work towards recovery.

Bridget Hamilton, Cath Roper, Flick Grey
Sharing co-production expertise: consumer involvement station

In 2011, academics at the School of Health Sciences were granted seed funds to establish a real and virtual meeting place, called Consumer Involvement Station. It is designed to bring into one space mental health consumers, clinicians, managers and academics who wished to work together - or to co-produce - mental health teaching, research projects and service provision. In the Victorian setting, people who have prominently contributed user/consumer views over two decades have mostly been employed either part-time as Consumer

Consultants or sessionally in reference groups. These roles have been embedded in services, leading to Consumer Consultants' roles in particular becoming overstretched, yet with limited development of new roles and inclusion of new people. And, despite enthusiasm among students and academics for learning from consumers, real partnerships in teaching and research are rare. The intention behind setting up the Consumer Involvement Station was to bring together interested people, and to celebrate excellent co-produced activities and existing expertise, in order to open up more spaces for co-producing teaching and research, both in Universities and in service settings. The Consumer Involvement Station (CIS) stakeholders included non-government support service providers, consumer peak bodies, universities and health services. The instigators, a nurse academic and a consumer academic, recognised that there were people of goodwill across these sectors who either did not know about the work being done by others in such partnerships, or lacked sufficient people or time to expand good work. The paper will describe the development and impact of the two main CIS products: a webpage showcasing excellent co-produced work, explained against a framework; and real meetings of interested people, at a CIS event.

Beate Schrank, Tamsin Brownell, Francesca Pesola, Mike Slade
Wellfocus positive psychotherapy group for people with psychosis: results of a pilot randomised controlled trial

Modern mental health services are aiming to embrace both a clinical and personal perspective on recovery from severe mental illness, such as psychosis, focusing on symptom reduction and on individual wellbeing. However, interventions that explicitly address wellbeing in this client group are scarce. This pilot study tests positive psychotherapy adapted for people with psychosis (WELLFOCUS PPT) to improve wellbeing.
Method
WELLFOCUS PPT was tested as an 11-week group intervention in a convenience sample of people with psychosis in a single centre RCT. Patients were individually randomised in blocks to receive either WELLFOCUS PPT in addition to treatment as usual (TAU), or TAU only. Assessments occurred pre-randomisation and post-therapy. The primary outcome was wellbeing; secondary outcomes included symptoms, depression, self-esteem, empowerment, hope, sense of coherence, savouring beliefs, and functioning. ANCOVA was used to estimate the main effect of group on all outcomes. Results: Intention-to-treat analysis showed no main effect of WELLFOCUS PPT on wellbeing (Warwick-Edinburgh Mental Well-Being Scale) but significant effects on symptoms (Brief Psychiatric Rating Scale, p=.006, ES=.42) and depression (Short Depression-Happiness Scale, p=.03, ES=.38). Sensitivity analysis adapting for therapy group, age, and gender further improved the results for symptom reduction and depression whilst also significantly improving quality of life and empowerment (p=.004, ES=.50; p=.03, ES=.44).
Conclusions
WELLFOCUS PPT was feasible in people with psychosis, positively affecting symptoms and depression. However, the main target of the intervention, wellbeing, did not show change. Future research might specifically test positive psychotherapy to address comorbid depression in psychosis, focus on symptoms, and consider alternative measurements of wellbeing.

Simon Riches, Beate Schrank, Mike Slade, Vanessa Lawrence
Therapist self-disclosure in positive psychotherapy for psychosis

The WELLFOCUS study used theory and a psychological model to modify and manualise a

positive psychotherapy intervention (PPT) for psychosis. The resulting 11-session group therapy, called WELLFOCUS PPT, was tested in a pilot RCT at 6 sites in South London. A key component of WELLFOCUS PPT was therapist self-disclosure. Therapist self-disclosure was defined as any self-revealing statement made by therapists during WELLFOCUS PPT group therapy. WELLFOCUS PPT explicitly encouraged therapist self-disclosure about positive, rather than negative, things.

Method

This study is a two-part qualitative study, using interview data from trial therapists (N=6), to evaluate the trial therapists' views on their self-disclosures. Qualitative analysis was done in two stages. Stage 1 was a thematic analysis of a section of a general post-RCT feedback interview. Two researchers used this thematic analysis to develop a topic guide and questions for Stage 2 interviews. Stage 2 interviews examined therapists' views of self-disclosure in more detail. Nvivo9 was used to analyse all data.

Results

In Stage 1, elements of self-disclosure that trial therapists found more effective than others were identified, such as normalising experiences and reducing the 'them and us' distinction. Another important influence was therapist pre-conceptions. Identified key themes were challenges with personal subject matter, self-regulation, authenticity, setting/context, and power. Stage 2 interviews and analysis are ongoing.

Discussion

Much traditional psychotherapy urges caution with therapist self-disclosure. Given the positive focus of WELLFOCUS PPT, therapist self-disclosure focused on positive aspects of therapists' lives, which is why it functioned to normalise experiences and reduce the 'them and us' distinction within the therapeutic alliance. Limitations of therapist self-disclosure in the context of PPT are also discussed, in relation to the way PPT breaks with traditional approaches.

Tamsin Brownell, Simon Riches, Beate Schrank, Mike Slade

The wellfocus study: development of an intervention to increase well-being in people with psychosis

Well-being is an important outcome in the context of recovery from severe mental illness. However, to date there are no established evidence-based interventions that specifically aim to increase well-being in people with psychosis. Positive Psychotherapy (PPT) is an existing intervention to increase well-being, which has been developed and tested with people with common mental health problems and in healthy participants. It is a promising approach to increase well-being also in people with severe mental illness, such as psychosis. We present the results of a study which aimed to adapt PPT specifically for people with psychosis.

Method

The adaptation process involved semi-structured interviews with service users with psychosis (N=23) and staff (N=14), expert consultation, manualisation and stakeholder review.

Results

Service user and staff interviews identified categories of adaptations to standard PPT. Results from the expert consultation focussed on session content and continuity and further adaptations needed to reflect the needs of the client group, such as concentration and motivation difficulties. Following manualisation of the adapted intervention, a stake-holder review suggested final changes, including more emphasis on repetition and maintenance of gains and the importance of therapists being genuine and realistic. The adapted intervention - called WELLFOCUS PPT - is provided as an 11-session weekly group therapy. In comparison with the original intervention, aspects of forgiveness and family involvement were de-emphasised. Exercises targeting savouring, mindfulness, hope and positive emotions, as well as a focus on identifying and nurturing personal strengths were

maintained. *Conclusion*
We show it is possible to specifically target well-being in a group intervention for people with psychosis. Offering the WELLFOCUS intervention in routine mental health practice may be a valuable addition to existing recovery oriented care.

Session 5.4 System transformation (Comm-unity care room)

Richard Byng, Lorna Rose, Cath Quinn, Lynne Callaghan
Resource mobilising individualised recovery

Innovation, theory and practice in recovery are all developing in parallel - often building on pre-existing good practice. Initially focused on individuals with severe mental illness (SMI), 'recovery' is potentially applicable to individuals with a range of mental and even physical health problems. This paper describes the early development of a model related to mobilisation of existing resources to achieve individualised goals as a part of recovery.
Method
We used a Realist Evaluation framework to incorporate: 1) analysis of common components within complex interventions undergoing development in two NHS funded research programmes (Engager 2 - for prison leavers with common mental Health problems and substance misuse; Partners 2 - a primary care based intervention for individuals with SMI); 2) reflection of practitioners based in Icebreak, an innovative youth outreach service for 'emerging personality disorder' 3) a literature review of key concepts identified in 1&2.
Results
Initial assumptions: a) individuals need to define their own goals and how they achieve them; b) these goals may include emotional states, behaviours and social inclusion and are interlinked; c) existing resources, often outside of health services need to be optimised; d) therapeutic skills of practitioners are important means of achieving the mobilisation of resources Three types of resources were identified as important: 1) the individuals'; strengths - skills, physical capacity, motivation; 2) the wide range of existing resources in the community including spaces, people, activities, as well as other organisations; 3) practitioners' individual strengths and capacities should be utilised in alignment with the individuals, rather than purely following protocols.
Discussion
In times of increasing cuts in services it is important to understand how existing resources are conceptualised and mobilised to achieve recovery for a range of marginalised and excluded individuals.

Sanaz Riahi, Ian Dawe, Phil Klassen
A recovery oriented approach in the prevention of restrain and seclusion in a Canadian mental health hospital

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a 339-bed teaching hospital specializing in comprehensive mental health and addiction services for those with complex serious and persistent mental illness. Our recovery-oriented model of care places direct emphasis on the collaboration with patients and families to implement a proactive approach towards care. One goal is the early identification of alternative interventions for patients who may be at risk for restraint or seclusion (R/S) use and proactive implementation of a management plan as a preventative approach to strengthening the therapeutic alliance.

The utilization of R/S interventions continues to occur throughout our inpatient clinical settings despite existing evidence related to its ineffectiveness and we aim to develop organizational strategies to prevent its occurrence. Our experience corroborated by literature, suggests that R/S events are traumatizing for both patients and staff and are associated with treatment failures.

Method

Evidence supports the need for multiple methods to reduce R/S use. Ontario Shores has adopted the Six Core Strategies framework in its multifaceted endeavour of preventing the use of R/S. This is a multi-year quality assurance strategy towards the Organization's goal of recovery-oriented care, encompassing R/S prevention. The multidimensional organizational strategies lend focus to: training, assessments, debriefing, leadership commitment, data and policy.

Results

Since 2006 there has been an overall reduction of 88% in the total incidents of restraint use, 24% reduction in the total incidents of seclusion and 21% reduction in the total incidents of chemical restraints.

Discussion

Key lessons learned are the need for unwavering Senior Management support, over communication, engagement of all stakeholders, and the need for the development of a sustainability strategy. Key challenges have been resources to implement and sustain the changes, internal and external stigma, and the existence of serious data accuracy issues related to process and practice.

Ian Dawe, Phil Klassen, Sanaz Riahi

Implementation of recovery rounds in the prevention of restraint and seclusion

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a teaching hospital specializing in comprehensive mental health and addiction services for those with complex serious and persistent mental illness. The facility, in Whitby, Ontario, Canada has 17 specialized inpatient units and extensive outpatient and community services. The Centre is staffed by approximately 1200 employees and provides mental health treatment for 339 inpatients, with approximately 50,000 annual outpatient visits. The presentation will review a key communication activity in advancing a culture of excellence and quality and safe care, Recovery Rounds

Method

Our recovery-oriented model of care places direct emphasis on effective communication with patients and families in order to implement a proactive and collaborative approach towards care. The purpose of Recovery Rounds is to elevate the importance of restraint minimization and recovery-oriented care through witnessing of restraint and seclusion events by senior staff. The Recovery Team is comprised of representatives from Senior Management, Professional Practice (PP), Peer Support Specialists (PSS) and Ethics. On a daily basis one member from each group attend all Code Whites and the daily unit Recovery Rounds.

Results

Our most recent data indicates an overall reduction of incidents of mechanical restraints from 3,101 in 2006 to less than 200 in 2013. A more in-depth data analysis of the specific effectiveness of Recovery Rounds will be shared in the presentation.

Discussion

Witnessing contributes to organizational change through oversight, accountability, timely communication, and the commitment that will surround every restraint and seclusion event. It also provides an opportunity to work with teams to collectively identify strengths as well as opportunities for improvement in restraint prevention techniques. Further, the learnings from other units can be shared consistently and with transparency across the organization.

Philip Klassen, Sanaz Riahi, Ian Dawe, Andrea Porter
Intimacy recovery: supporting patient intimacy in an inpatient mental health setting

Ontario Shores Centre for Mental Health Sciences is a 340 bed specialized mental health facility near Toronto, Canada. We are a University of Toronto affiliated teaching hospital. The hospital is comprised of general psychiatry, forensic psychiatry, geriatric psychiatry and adolescent psychiatry programs; there are also units serving dually diagnosed and neuropsychiatry patients. The hospital administration is committed to Recovery, albeit the patient intimacy journey began as a risk management intervention, in the context of the recommendations of a Coroners' Jury. The process evolved, though, along more clinical lines, and ultimately a very committed stakeholder group was assembled, with the full support of the hospital administration. This process, with important input from persons with lived experience (who now "own" it), led to the creation of a policy supporting intimacy, regular assessment of capacity to consent to sexual relations (in the service of harm reduction), training and support for staff and patients in terms of providing information and education on relationships, intimacy and sexuality, and dedicated private space in hospital for use by patients seeking a sexual relationship with a partner. This presentatoin will review the process, and the unique challenges that this initiative faced. We will also review utilization, patterns of use, and satisfaction. *Method*
We administered a survey to patients who used the space we developed, asking a variety of questions to help us understand the needs of the users, access issues, and general satisfaction.
Results
The space is used regularly, often by established couples. The same couple(s) tend to use the space repeatedly. User surveys are being compiled and we will present data on satisfaction, and from the service users' perspective, at the meeting.
Discussion
From the perspective of this organization, this process has been a success, and thus far there have been no untoward events. The space is being utilized, and a review of user satisfaction will help direct next steps.

Sarah Brand, Cath Quinn, Mark Pearson, Richard Byng
Engager 2: developing and evaluating a collaborative care intervention for prisoners with common mental health problems, near to and after release

Offenders have higher self-reported rates of common mental health problems (CMHPs) and substance misuse than the general population. However, CMHPs in this population are an unmet need in comparison to substance misuse; offenders with CMHPs have low service receipt in comparison. Responding to this unmet need for offenders will require a collaborative recovery-focused response across services.
Method
A Realist Review of the literature informs development of an intervention to provide recovery-focused holistic care for offenders with CMHPs in prison and through the gate in to the community. The review looks at care that has been shown to work for offenders and other vulnerable groups, particularly how practitioners across different services can work effectively together and the aspects of relationships that support recovery in vulnerable populations.
Results
The underlying principles of recovery-focused care for this population include collaborative care defined by the personal goals and objective needs of the offender, a strengths-based

approach for both the practitioner and the offender, and a focus on enabling effective liaison and shared working practices between criminal justice, health and resettlement services in prison and the community. These principles can be delivered through an iterative care plan to achieve ongoing goals and needs, the building of a supportive therapeutic relationship focusing on building offender capabilities and skills, liaison between practitioners around the individualised care plan, and appropriate peer support. Continuous monitoring and updating of goals, needs, and the care plan to address them is supported by the relationships of practitioners with each other and with offenders.
Discussion
The resulting recovery-focused intervention will support services to work collaboratively across service boundaries around a shared care plan to support identification and realisation of personalised goals and objective needs. Relationships form the foundation for the iterative development and delivery of the personalised care plan.

Session 5.5 System transformation (Hoping for more room)

Trentham Furness, Brian McKenna, Deepa Dhital
Supporting recovery in acute adult in-patient mental health services

NorthWestern Mental Health (NWMH) is one of the largest publicly funded providers of mental health services in Australia. A new policy of the Australian Government will require all public mental health services to become recovery-oriented. The intent of this qualitative study was to allow mental health nurses working in acute adult in-patient units the opportunity to reflect on and describe current practice in a service that is not yet obliged to use a recovery-oriented model of care. The aim was to determine the extent to which elements of existing nursing practice resemble the domains of recovery-oriented care.
Method
Focus groups with mental health nurses (N = 46) were conducted at each of the five acute adult in-patient services at NWMH. Each of the focus groups explored the meaning of the nine domains of recovery according to the Australian Government Department of Health.
Results
Mental health nurses expressed the need to gently prepare the recovery-oriented pathway despite the challenge of the acute in-patient unit; high acuity, rapid turnover, risk assessment and management, and involuntary treatment. Results of this study describe the extent to which mental health nurses pragmatically apply a recovery-oriented model of care in acute in-patient mental health units that are not yet obliged to be recovery-oriented.
Discussion
These findings support earlier work of nurses' awareness of recovery-oriented care and add description of nurses'; willingness to engage in a model of care that supports empowerment, social inclusion, and peer-support through advanced directives, care planning, protected therapeutic time, and continuity of care. Pragmatic examples of sensitivity to cultural behavior and spiritual processes by nurses in this study are supported within existing mental health nursing literature and further reinforce the intent and full potential to be recovery-oriented when the momentum of policy change is reflected in mental health service reform.

Trentham Furness, Brian McKenna, Deepa Dhital
Becoming recovery-oriented at a secure adult in-patient mental health service

NorthWestern Mental Health is one of the largest publicly funded providers of mental health services in Australia. A new policy of the Australian Government will require all public mental health services to become recovery-orientated. The intent of this study was to describe the procedures and processes that supported systemic transformation of a secure adult in-patient mental health service, prior to national policy implementation.
Method
This qualitative work was conducted as an illustrative case study of the transformation of a nurse-led secure in-patient service to a recovery-orientated service. One-to-one interviews were recorded with six consumers and ten multidisciplinary staff. One focus group was held with ten carers. A document search and analysis was conducted of meeting minutes, surveys, project briefs, project reports, unit policies, memos, and service-wide policies or protocols.
Results
System transformation was dependent on an all-of-service vision. A template was created as part of this vision and this secure service modified the template to suit specific needs. As such, the major procedures and processes that supported system transformation were; (1) acknowledgement and buy-in of multidisciplinary mental health staff of the recovery-oriented care paradigm, and (2) flexible policies to suit each consumer.
Discussion
The gradual transformation to a recovery-oriented service remains ongoing. However, consumers and multidisciplinary staff agree that the service supports the domains of recovery to a greater extent since the shift in care philosophy commenced in 2006. The support of the mental health service, from executive to senior clinicians, was fundamental to allow transformation. As buy-in of service users and providers was a common requisite, transformation in part, was dependent on champions at both levels within this secure adult in-patient mental health service.

Nicola Wright
Promoting recovery through knowledge sharing: a qualitative study of care transitions into and out of acute inpatient ward

Research from non-mental health settings highlights the complex systems of interacting and interdependent actors involved in transitions of care. Knowledge sharing as a basis of collaboration and coordination is crucial within this context. However, these ideas have not been applied to mental health services. Admission into and discharge from inpatient wards are still perceived to be one-off events. This disjointed view of care can have a detrimental effect on the recovery journey.
Method
One acute inpatient ward was the focus of the study which utilised a qualitative, improvement science methodology. Six focus group interviews (n=42) were conducted to understand participants experiences of the processes involved in knowledge sharing during admission and discharge from the ward. The participants were: consultant psychiatrists (n=15), junior doctors (n=4), ward nurses (n=8), service users (n=4) and staff from two community teams (n=11). All participants gave informed consent. The focus groups were audio recorded, transcribed verbatim and analysed using conventional qualitative thematic methods.
Results

Participants identified that care transitions into and out of the ward were challenging and referred to a 'bunker mentality'. In relation to knowledge sharing participants described giving away lots of information but receiving little of use in return. Service users described a disrupted process whereby each transition resulted in changes in their care which they often felt they had not agreed to or understood.
Discussion
The 'revolving door' and the detrimental effects this has on recovery are well documented. However, the concepts of knowledge sharing and care transitions locate this issue within the context of a whole system. Actors within it have a responsibility to obtain the information which they need and not passively receive what others are willing to share.

Mick McKeown, Chandley, Fiona Jones, Gary Thorpe
Researching and developing recovery initiatives in a high secure hospital

This paper presents an outline of three interlinked recovery initiatives taking place within Ashworth High Secure Hospital. These are: (i) co-ordinated service developments including the introduction of recovery champions roles, development and implementation of a 'recovery star' assessment tool for high secure settings, and the establishment of a recovery college; (ii) participatory action research focused on developing recovery innovations with ward teams; and (iii) qualitative inquiry with service users and staff exploring different understandings of recovery within the high secure context.
Method
Mixed methods were deployed. These include, participatory approaches to service development, participatory action research (PAR) at ward level, qualitative data collection using semi-structured interviews and focus groups with a purposive sample of multi-disciplinary staff (n =30) and service users (n = 30) with thematic analysis.
Results
We present outline findings in three ways: Description of specific service developments and how these have been achieved and co-ordinated across the hospital. An account of ward level innovations and the process of change resulting from the PAR study. Key themes emergent from the qualitative study which illustrate how staff and service users make sense of recovery and how the concept might inform practice in a high secure context.
Discussion
The discussion will highlight the ways in which the recovery concept can be meaningfully translated into high secure settings. There will be an emphasis on findings common to the three initiatives presented which highlight: the value of democratic participation of staff and service users in a context of service development; specifically how action methods can underpin innovation and sustainability; a central role of relationships with patients and within teams in supporting recovery focused outcomes; and the ways in which recovery work can intersect with efforts to promote patient autonomy and responsibility, and hence minimise risk.

Myra Piat, Judith Sabetti, Paul Morin, Deborah Padgett
Moving from custodial housing to autonomous housing: a study on transformative change and recovery

In this presentation we will explore how people with mental illness recover and build a life beyond the mental health system in moving from custodial housing to autonomous housing in the community. People living in custodial housing are given little opportunity to exercise choice, and make their own decisions. Custodial housing creates dependency, and deprives

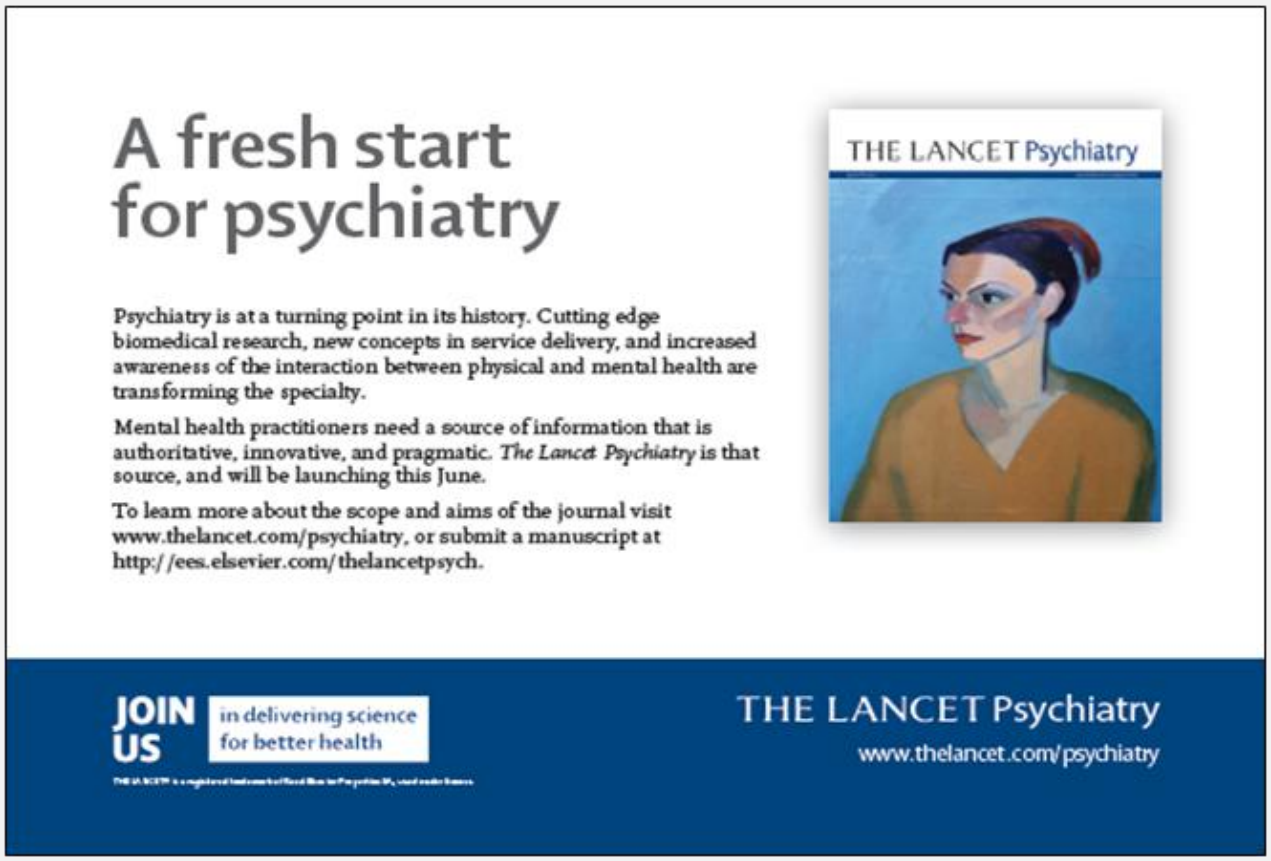
people of legitimate choice in various aspects of daily living. In response to this crisis new and innovative types of housing involving inter sectorial partnerships are being developed to replace the traditional, custodial model.

Method

In this presentation we will describe) how the transition from custodial to autonomous housing helps or hinders mental health recovery and community integration for people with serious mental illness; 2) how this new autonomous housing, organized through inter sectorial partnerships, promotes (or hinders) the recovery orientation of housing services. The study takes place in Toronto, Montreal, Sherbrooke and St John's. The sample includes 4 new autonomous housing projects. Using a transformative conceptual framework we will draw upon empowerment theory, recovery and inter sectorial literature to illustrate how these new models of housing are transforming the housing network. The research design includes qualitative/ethnographic methods: Qualitative interviews will be conducted with residents; key stakeholders/intersectorial partners including: housing staff, mental health service providers, regional planners and family members.

Discussion

This research is one of the first known attempts in Canada to provide an in-depth understanding of the experiences of mental health consumers living in autonomous housing in terms of their community integration and recovery. The study will provide new information on the added value of the new inter sectorial partnerships, both in terms of their impact on the person, and in terms of how the various partners see themselves as creating more recovery-oriented services for people with serious mental illness living in the community. This research is critically important to better understanding how this new type of housing is (or not) transforming the current housing system. It will inform the development of a national housing policy currently lacking.



POSTER PRESENTATIONS
Camaraderie room

Poster 1
Agnes Chevalier, Clair Le Boutillier, Victoria Bird
Staff understanding of recovery-oriented practice - A systematic review

The implementation of recovery-oriented practice is an increasing priority within mental health services. Whilst the concept of recovery is by definition individual, and born out of the service user perspective, a shared understanding may be necessary for staff in order to close the implementation gap. Similarly, little is known of staff perspectives on recovery. The aim of the review was to assess what staff understand by recovery-oriented practice.
Method
A systematic literature search was conducted to identify empirical primary research assessing staff's knowledge of, views on, or evidence of recovery-oriented practices. A proportion of the records (20%) were screened by a second rater and any disagreements were discussed and used to refine the eligibility criteria. The included qualitative and quantitative papers were analysed using narrative synthesis, where the results were first tabulated and the relationships between the studies examined. Thematic analysis analysis was then used to synthesis the qualitative results.
Results
Online databases searched returned 10,166 unique hits, which were screened for eligibility. The main themes identified within the narrative synthesis will be presented here.
Discussion
Implications for practice and research are discussed.

Poster 2
Ben Fortune, Mary Leamy, Julie Williams, Mike Slade
The role of goal attainment and type in promoting well-being as an aspect of recovery

Individualised outcomes are an important part of the recovery concept. Goal attainment is one such mode of individualising mental health outcomes that can increase well-being within non-clinical samples. However, there is a lack of empirical data concerning the use of goal attainment, and specifically goal categories, within a clinical setting and its effectiveness for increasing well-being. *Method*
Goal records of 347 individuals using mental health services in England were reviewed to examine goal content, goal progress and change in goal importance across one year. Change in Well-being score across one year will also be looked at (using the Warwick-Edinburgh Mental Well-being Scale). *Results*
Main results will be presented here.
Discussion
Implications for practice and research will be discussed here.

Poster 3
Bror Just Andersen, Anne-Grethe Skjerve
All inclusive - or not?

When establishing assertive outreach services in Norway the answer has largely been

establishing ACT-team or similar with diagnosis based admission criteria. The risk is however that one creates new errors in the patients flow and new groups falling outside treatment, relative to the goals. In Baerum we turned it bit upside down, and the 01.01.12 we established a collaborative team where the main admission criteria is poor or total lack of connection to services. Diagnosis is not used as the basis for admission, and age is immaterial. The project has developed a flexible, functional, committed collaboration model for primary and secondary mental health and substance abuse services; the C-Flex model. We have created an interdisciplinary collaboration team of employees in fractional positions also still staying in their initial positions.

Method

The objectives for the intervention is that people with prolonged, severe mental illness and / or severe substance abuse disorder and poor or lack of connection to public services gets unified and coherent treatment and services. The purpose of the evaluation is to examine the effect of the teams work according to the C-Flex model has on the target group's functioning, quality of life, substance abuse and mental health. We seek to answer these questions through mapping, using validated measuring instruments and through reviews of changes in known risk and protective factors. It is an intervention study with cohort design. Registration of outcome variables are when possible be at admission to treatment (t0), after 3-6 months (t1) and after 12 months.

Results

The inclusion of patients started 10.2012. The evaluation has much parallelism to the national evaluation of the ACT-teams in Norway. We therefore have an agreement about using the other's data as control group. The Poster will present development of C-Flex, experiences, methodical approach, preliminary results.

Poster 4

Carly Reagon, Gail Boniface

The nature of recovery outcomes for people with mental health problems living in the community

The aim of this study was to investigate the meaning of recovery-based outcomes for staff and clients in a community based mental health project in Wales. Use of outcome measures is encouraged universally, however because of the highly individualised nature of mental health, what is meant by a recovery-based outcome is not always clear and may differ depending upon the standpoint of the person looking at it.

Method

Staff (n=6) and clients (n=8) were involved in a series of research groups as part of a wider action research project. Issues covered included the nature of recovery outcomes and the terminology used to describe them. Qualitative data were captured by audio recorder and field notes and transcribed verbatim where appropriate. These were then subject to thematic analysis.

Results

The action research groups generated a large amount of data on the nature of recovery outcomes as perceived by staff and clients. The size of outcomes was not considered important, as long as they were individualised and meaningful to the client involved as well as being realistic and achievable in the given time frame. The importance of appropriate language in discussing outcomes with clients was underlined. Terms such as ‘goal’ were rejected as creating too much pressure on clients to succeed, conversely leading to failure.

Discussion

Clients welcomed the opportunity to discuss recovery outcomes and demonstrated that their involvement at this level of service planning (developing an outcome measure) is both appropriate and helpful. The study identified dissimilarities as well as commonalities between how staff and clients understand and talk about recovery-based outcomes

particularly in terms of the language used, creating important messages for those involved in both recovery-based service design and delivery.

Poster 5
Charley Larkin, Tamsin Brownell, Zivile Jakaite, Mike Slade
Optimising WELLFOCUS PPT – a positive psychology intervention for psychosis

Positive Psychotherapy (PPT) is a strengths-based therapy which aims to improve wellbeing and was originally developed for people with depressive symptoms. It was adapted for people with psychosis generating an 11-session group therapy (WELLFOCUS PPT). WELLFOCUS PPT targets four areas of development: amplifying strengths, increasing positive experiences, fostering positive relationships, and creating a more meaningful self-narrative. An RCT was conducted and subsequent follow-up interviews were carried out with participants and therapists. The aim of this study was to use this follow-up data to modify and improve WELLFOCUS PPT.
Method
Qualitative interviews were conducted post-therapy and four researchers independently coded all or a portion of the transcripts. The transcripts were coded deductively and inductively on a series of Excel spreadsheets in order to develop a coding framework which was analysed using descriptive rather than interpretative methods of analysis.
Results
Suggestions fell into three categories: general changes, PPT-specific changes, and changes to reflect the client group. General changes suggested include maximising the usefulness of between-session exercises and developing a strategy to maintain new skills after the group had ended. Additionally, feedback from participants and therapists regarding PPT-specific changes mentioned the importance of explaining the rationale of both the intervention and each exercise; emphasising that PPT is strengths rather than problems focused. Also, suggestions to optimise the between-session phone calls and increase therapist self-disclosure were noted. Changes to reflect the client group included addressing the disparity between the cognitive impairments of some participants and the complexity of certain topics whilst making sure there is adequate support during difficult sessions (e.g. forgiveness and gratitude).
Discussion
Suggested changes will be used to adapt WELLFOCUS PPT to improve its feasibility and helpfulness. The adaptations can also be used by clinicians when deciding how to optimise both positive psychology interventions and other therapies for psychosis.

Poster 6
Claire-Odile McCauley, Professor Hugh McKenna, Dr Sinead Keeney, Dr Derek McLaughlin
Exploring young adult service user perspectives on mental health recovery

Recovery research has suggested that ‘recovery from’ symptoms of mental illness is only part of the recovery journey, that ‘recovery in’ the experience of mental illness through hope, the re-establishment of identity and social inclusion are essential (Slade 2010). This study will explore if the experience of suffering contributes to the generation of hope, meaning and growth (Erikkson 1993). It will examine the sustainability and real life application of key proposed components of recovery, or if a core internal process is necessary to reshape the self (Romano et al. 2010) and ultimately re-author the process of recovery (Onken et al.

2007). This study will further explore if young adults' perspectives of their condition needs 'reshaped' to contextualise it within their own conceptualisation of recovery. The aim of this study is, therefore, to explore young adult service user perspectives on mental health recovery.

Method

The study will involve three phases using qualitative methodology. Phase 1: a concept analysis of recovery, to refine the meaning and the defining attributes of the concept. Phase 2: Two engagement groups with service users will be undertaken to assist the development of the semi-structured interview schedule. Phase 3: Semi structured qualitative interviews with 30 services users will be conducted to facilitate an in depth understanding of their lived experience.

Analysis

Gadamer's (1976) philosophical hermeneutic approach will be used to explore service users' perspectives on the concept of recovery by finding meaning in suffering (Erikkson, 1993) through 'reconnection with time' (Kartalova-O’Doherty 2012, p.142). Hermeneutic phenomenology will enable the exploration of subjectively lived experience of service users through the collection and analysis of word based data.

Conclusion

This proposed study will explore personal, social and cultural meaning of recovery. The exploration of young adult service user's perspectives on recovery could 'hear their experiences and aspirations and translate these into service design, planning, commissioning and delivery' (SCIE, 2007, p. 21).

Poster 7

Conan O'Brien, Jheanell Gabbidon, Arune Keraite, Mar Rus-Calafell

Reducing the frequency and severity of voices: A randomized clinical trial of a novel Audio-Visual Assisted Therapy Aid for Refractory auditory hallucinations (AVATAR therapy) compared to supportive counselling.

Around a quarter of people suffering from psychotic conditions like schizophrenia continue to experience auditory hallucinations (AH) despite adequate drug treatment. AH are typically threatening and denigrating and may also command the sufferer to harm themselves or others. Some help is also provided by psychological interventions, such as cognitive behavioural therapy for psychosis (CBTp) though the impact of these are modest at best (Wykes et al 2008). Furthermore, CBTp is costly, time consuming and has limited availability meaning that the therapy is delivered to only a fraction of those who might benefit. Consequently there is considerable interest in the development of novel therapies that build on the CBTp experience but which are more focused and capable of being delivered by a wider workforce (e.g. Garety et al 2008). AVATAR therapy is one such new technique. The approach is based on computer technology which enables each patient to create an avatar of the entity (human or non-human) that they believe is talking to them. The therapist promotes a dialogue between the patient and the avatar in which the avatar progressively comes under the patient's control. In an initial pilot study, a maximum of 7 sessions lasting 30 minutes resulted in highly significant reductions in the patients' hallucinations and the associated distress, enhancing the quality of their life (Leff et al., 2013).

Method

Research Question: Will AVATAR therapy reduce the severity and frequency of AH? Study Design = Randomised controlled trial with two experimental conditions: AVATAR therapy vs. supportive counselling. Inclusion criteria = Participants who have experienced persistent, undesired auditory hallucinations for at least 12 months despite treatment with medication. Recruitment target = 142. Primary Outcome = Total score on the auditory hallucinations component of the Psychotic Symptoms Rating Scale (PSYRATS-AH, Haddock et al 1999) at 12 weeks.

Results
Due 2016.

Poster 8
Deana Davalos, Joy DeJong
The Role of Multidisciplinary Treatment Variables in Improving Perceptions of Quality of Life

Quality of Life (QoL) is a concept that is thought to go beyond simply assessing one's well-being, but more broadly one's life satisfaction. While clinicians generally agree that a goal of treatment is to improve one's QoL, there is little research addressing what treatments appear to best meet this goal. Even fewer studies have examined the role of QoL in neurological populations. An important question that is poorly understood is whether certain therapies appear to improve QoL broadly across populations or whether certain therapies may be more valuable depending on one's neurological symptoms and psychological status.
Method
Patients with various neurological diagnoses who enrolled in an outpatient multidisciplinary neurological treatment facility were assessed across a variety of measures from the Neuro-QOL item bank assessing satisfaction with social roles, affect and well-being, applied cognition, and ability to participate in activities in pre-and post-treatment surveys. Patients received a variety of therapies and or simply diagnoses via neuropsychological evaluation.
Results
Preliminary findings suggest that certain therapies (e.g. occupational therapy) appear to be linked with broader gains across QoL measures ($p < .10$) and conditions while other therapies appear to be linked to more specific QoL gains.
Discussion
Findings suggest that there are different treatments that should be customized for specific deficits across neurological conditions to better improve one's QoL.

Poster 9
Emma Swan, Mervyn Morris, Lucy Land, David Wilde
Recovery, an Alienist concept? The Impact of Recovery on mental health professionals

Service users with severe mental illness often report that one of the most significant factors in their recovery process is how people, especially mental health professionals, interact with them. If this assertion is true then it is vital to gain an understanding of how professionals are working with individuals to support recovery. The aim of the research is to explore mental health professionals' understanding, experience and meaning-making of the concept of recovery from mental illness. *Method*
A multiple perspective Interpretative Phenomenological Analysis (IPA) design was chosen as the method of qualitative inquiry. Three directly related groups of mental health professionals will be interviewed about their experience of working with recovery. This will offer an insight of recovery from different perspectives as all professionals will be immersed in the experience but are likely to have different views of it.
Implications and Discussion
The benefit of using IPA to explore recovery from multiple perspectives allows for more complex views of the context and dynamics of personal experience. It also provides an increased inferential power and contextual range. The insight into the relational context of experience may be able to assist in the development of recovery plans that provide guidance

for professionals, and to deliver strategies for training programmes which could increase knowledge and skills. Ultimately these advancements could lead to substantial real-world significance in helping both mental health professionals and service users to thrive.

Poster 10
Eva Biringer, Bengt Sundfør, Miriam Hartveit, Marit Borg
While waiting for treatment service users in mental health care take active roles in their daily struggle against the emotional problems and everyday challenges they experience

Mean waiting times are 55 days in Norwegian public mental health care (1). The present study aimed at exploring service users' experience of waiting for care at a Community Mental Health Centre (CMHC), with a particular focus on what they do to help themselves.
Method
Ten service users who had just started receiving treatment at a CMHC in Norway participated in a semi-structured interview including questions about waiting time experience and what they did to help themselves. In the context of a phenomenological approach, data were analyzed and discussed within a reflexive-collaborative framework including one co-researcher with lived experience.
Results
Several of the informants revealed feeling exhausted and experiencing shortcomings in their daily lives. However, the informants took active roles and developed strategies to pursue their valued activities. Several of them continued working, and nearly all tried to keep up with their domestic tasks. Regular physical exercise, walks in nature, and keeping up contact with family and friends were actively used as tools for releasing emotional symptoms and getting rid of tensions. Some of them also found that waiting provided an opportunity for preparing themselves for treatment, for instance by gathering information about their condition or planning what to say during the first consultation. *Discussion*
Waiting time is not a period of passivity and helplessness. While on waiting list, service users in mental health care are active participants in their own everyday lives, actively using strategies to handle everyday challenges as well as preparing for treatment.

Poster 11
Genevieve Wallace, Victoria Bird, Julie Williams
Assessing service user strengths in practice

Recognising and building on individuals' strengths is a key component of recovery-supporting practice. Strengths assessment was one of the three working practices in the REFOCUS intervention, and training on its implementation was given to staff in intervention teams. This study aims to investigate whether the service user strengths assessments were implemented as intended and identify any potential modifications to the strengths worksheet tool and associated training.
Method
An audit was carried out of the service user strengths assessments (n=64) recorded by staff in the REFOCUS trial (ISRCTN02507940) on the electronic patient records system (ePJS). They were accessed in anonymised form through Case Register Interactive Search tool (CRIS) and were analysed using thematic analysis.
Results
Initial analysis indicates that service user strengths were most often reported in the areas of occupation (53% of service users), personal qualities (45%), daily living (41%), and social

supports (39%). Some recorded strengths demonstrated an individualised and rich discussion, with a holistic understanding of the individual. In other cases the strengths assessment tool had been used as a checklist, and where the service user had been unable to report a strength, a deficit was recorded. Both strengths-based and deficit-based language were employed.
Discussion
Some but not all staff demonstrated excellent understanding and implementation of a strengths-based approach. Recommendations will be made for potential modifications to the REFOCUS strengths worksheet tool and associated training, as well as general recommendations for implementing a strengths-based approach in community mental health teams.

Poster 12
Helene Regle
Welcome to the chaos - A scientific metaphor to get out of the tracks of an attractive position of patient

This work explores the scientific understanding of the dynamic transformation in material systems, believing that this could give clues for welcoming and sustaining the process of persons in recovery. *Method*
The metaphor is used between the recovery processes and the non-linear system transformations. *Results*
Non-linear material systems tend to be attracted by their own stable positions, as soon as their historic trajectory approaches them. The system can however reach one of his new structural positions, if bifurcations in its trajectory are favoured by an opening of its frontier, allowing apparently random fluctuations from its state. Due to a very high sensitivity to initial conditions, the science recognizes now that the achieved new positions are unpredictable, although deterministic for a given system. *Discussion*
It is discussed how the position of patient could act as a stationary attractor for many persons crossing the illness and not-recovery oriented institutions. It is supposed that new stable positions are achievable through bifurcations, if the noisy fluctuations induced by an opening out of their systems are sustained. Considering the sensitivity to initial conditions, the way toward these other possible positions would structurally need to be done with the believing in the auto-determination of the person.

Poster 13
Janice Connell, John Brazier
Developing a Recovery of Quality of Life Measure

The development of a recovery of quality of life measure originated from concerns that generic quality of life measures used in the economic evaluation of mental health interventions were not appropriate for people with mental health problems.
Method
We undertook a systematic review of qualitative research on quality of life undertaken with people with mental health problems. The review primarily included people with schizophrenia and psychosis. To complement the review we undertook semi structured in-depth interviews people who had a broad range of mental health problems at varying levels of severity drawn from primary and secondary care services.
Results
The framework analysis of 13 qualitative studies revealed six major themes: well-being and

ill-being; control, autonomy and choice; self-perception; belonging; activity; and hope. Despite widening the types and severity of mental health problems studied, our interview data fitted well with the themes from the review, any differences tended to be within the themes and related to the degree of impact of the themes on different levels of severity, chronicity and diagnosis. Physical health was also found to be more important amongst the interviewees, so it was added as a seventh theme.

Conclusions

The review of qualitative research and our own interviews raises important questions about the content validity of the EQ-5D and SF-6D in mental health. Importantly, when compared with a recent systematic review of personal recovery the recovery processes identified - 'connectedness', 'hope', 'identity', 'meaning in life' and 'empowerment' (CHIME; Leamy et al., 2011) which are very similar to our own final themes.

Going forward

We are taking forward our own research into quality of life and recent research into personal recovery to develop a new measure on Recovery of Quality of Life for the Department of Health and NHSE for use in secondary mental health care, to be completed by April 2015.

Poster 14
Kristin Ådnøy Eriksen
Being in relationships and being recognized

Even if recovery is referred to as 'a personal journey', it unfolds within a social and interpersonal context. How can focus on recognition of clients' personhood and intrinsic value as human beings (in relationships between health workers and clients) support clients' recovery?

Method

Interpretative phenomenological analysis of transcribed text from eighteen in-depth interviews with clients depending on community based mental health services in their daily lives, and transcribed text from four multi-stage focus groups with mental health workers resulted in four published papers. The focus was client's experience based knowledge about being recognized and how this knowledge could be part of the foundation for mental health workers' knowledge and clinical work. This poster synthesizes the results from these four papers with special attention to relationships as a potent element of recovery.

Results

Being recognized in relationships with other people can promote experiences of being a person who is worthy of respect; of being a person like other persons; of being a person whose contribution is worthwhile; and of being a person who makes an impression on, and makes a difference in other peoples' lives. These experiences are closely connected to elements associated with recovery like connectedness, hope, identity, meaning and empowerment (CHIME).

Discussion

Mental health workers can contribute to recovery by striving to acknowledge clients as active agents, allowing clients to be narrator in his or her life, and by being a counter force to clients' devaluations of own value. Being a professional mental health worker thus means to respond to the client's contribution in each present moment, and to acknowledge his or her intrinsic human value. This involves sustaining indecisiveness, being willing and ready to change opinion and perspective, and active re-evaluation of own practice to further develop ability to acknowledge each client in each present moment.

Poster 15
Lillian Sofie Eng, Deede Gammon, Monica Strand
PsyConnect - an online tool for assisted self-help in mental health recovery

The involvement of persons with lived experiences of mental illness and service use is increasingly viewed as key to improving the relevance and utility of mental health research and service innovation. This is a presentation of the development of an online tool for assisted self-help in mental health recovery.
Method
In line with community-based participatory research, a practice-research team consisting of service users, clinicians, IT-experts and researchers was established. Listening to and comprehending service users'; and clinicians' insights and priorities, while coupling this with research that helped us critique and refine our design decisions, was a continuous, iterative process and resulted in a pilot version of an online tool for assisted self-help. We will continue to adapt the tool together with service users and clinicians in two communities in Norway.
Results
PsyConnect has become a tool for those who expect to need assistance over long periods of time regardless of their specific condition(s). The aim is to support service users in gaining greater overview and control, legitimacy, and sense of continuity in relationships. It has a personalized 'my control panel' which depicts status ï*f* process ï*f* goals. Functionality includes support for: mapping life domains; medication overview; crisis management; coping exercises; diary, secure messaging; and social support.
Discussion
PsyConnect has undoubtedly become something other than it would have been without careful attention to the views of service users. The tool invites a proactive approach that is likely to challenge treatment cultures that are reactive, disorder-focused and consultation-based. Service user representatives will need to play central roles in training peers and clinicians in order to increase the likelihood of tool usage in line with intentions.

Poster 16
Lone Petersen and Merete Johansen
Recovery mentors

Employing people with lived experiences as peer support workers in the mental health services has for some time been considered a strategy for achieving a recovery-oriented mental health system. The peer support workers bring hope to the patients through their self-disclosure. They are role models and they can act as advocates for recovery and bridges between the staff and patients.
Method
In The Mental Health Care of the Capital Region of Denmark we have been conducting a pilot study since June 2013 with the aim of developing a peer support function as a recovery mentor in open and closed wards. We have employed six recovery mentors. They work as part in the staff thereby taking part in the conventional service delivery. A training program and a job and role description that focus on the unique qualities brought into the services by the recovery mentors has been developed in partnership with a peer organisation. All mentors meet biweekly in their own network.
Results
A preliminary evaluation shows that overall the staff feel that it helps them focusing on recovery. One of the challenges for the staff is the unclear boundaries between their and the

recovery mentors tasks, which the recovery mentors agree with. The patients state that it was very helpful to meet a person that was optimistic and understanding. The largest challenges for the mentors were to meet the lack of a recovery environment and to be confronted with direct and indirect expressions of prejudice towards the patients and themselves.
Discussion
The Mental Health Services has now decided to employ recovery mentors in all psychiatric centres. It is important to use both the positive and the negative experiences from the study, and to listen to the staff, the service users and the recovery mentors, as it is in partnership the transformation will occur.

Poster 17
Miriam Hartveit, Marit Borg, Eva Biringer
Service user involvement in the referral process within mental health care – a study in process

Referral letters are the main communication mean between Primary Care and Specialised Mental Care when a person needs mental health services. They form the basis for care-planning, and consequently should also include information regarding the persons' perspective of needs, and his/hers aims and desires towards the health care involvement [1]. However, such information is seldomly represented in these letters. Our study aims at exploring a) the prevalence of information regarding service user involvement in referral letters to specialised mental health care, and b) if and to what degree existence of this information in the referral letters affects the quality of health care received by the referred person.
Method
Using a validated checklist all referral letters from general practitioners (GPs) to the local mental health services in the region of Helse Fonna Local Health Authoriy in Norway (population: 165.000) during a period of two months will be scrutinised for information reflecting the service user's perspective.
Design
The study will have a user involved design involving a competence group of service users in all stages of the research process.
Analysis
The prevalence of information regarding user involvement will be described in general and for subgroups for instance by reasons for referral. Further, the predictive value of user-perspective information for quality of care will be explored within a linear regression models. Quality of care will be defined by a set of indicators currently being developed, measuring among others, and correctness of priority between service users.
Results
The knowledge generated by this planned study can lead to a better understanding of the role of information from the service user's perspective in the referral process and results will be useful in the work of improving the communication between health care users and providers.

Poster 18
Nadja Kehler Curth, Ursula Brinck-Claussen, Lene Falgaard Eplov
A Danish model for Collaborative Care in primary care

Collaborative Care (CC) models are suggested to represent useful additions to clinical

pathways in the treatment of anxiety and depression in general practice as they are associated with significant improvements in treatment outcomes compared with treatment as usual (TAU). However, studies have primarily been conducted in the U.S. Thus, a Danish system-adjusted model for CC (the Collabri Model) was developed with a special emphasis on the patient's preferences and choice of treatment. The model adapts to four criteria of CC: 1. A multi-professional approach to treatment including a care manager (CM) (i.e. nurse with psychiatric experience) and supervision by a psychiatrist, 2. Scheduled monitoring and review, 3. A structured treatment plan based on current guidelines and newest research and 4. Enhanced inter-professional communication. The aim of the study is to investigate the effects of CC compared to TAU in patients with GAD, panic disorder, social phobia or depression consulting their GP. Prior to baseline, all professionals will participate in a joint training in the Collabri Model and CM will further be trained in communication, psykoeducation as well as the principles of empowerment, self-efficacy and individual recovery.

Method

The study is set up as a researcher-blinded cluster randomized controlled trial with an intervention group (treatment according to the Collabri Model) and a control group (TAU). The primary outcome is self-reported symptoms. At 6 month follow up the patients will assess whether they have felt supported in their recovery by their health care provider. The INSPIRE questionnaire will be used in a translated version.

Results

The study will start medio 2014 and the results are expected medio 2017.

Discussion

Knowledge about the effects of a system-adjusted model for CC can contribute to the discussion of how the treatment of anxiety and depression in primary care can improve.

Poster 19

Gulbin Ozcelikay, Uzun Barlas Mehmet, Aykac Gazem

Pharmacists role on daily life of people in Turkey

The people who are graduated from pharmacy faculties, are a citizen of Turkish Republic and whose diplomas were registered by Turkish Ministry of Health and have no obstacle to profess. There are 23 pharmacy faculties in Turkey. Approximately 1500 students graduate per year. 30.000 pharmacists and 25.000 community pharmacies are providing service. Most of graduates are being responsible manager of a community pharmacy according to Turkish pharmacy legislation. A pharmacist can open one pharmacy and cannot be a responsible manager of another management. Community pharmacies are easily accessible health institutions for public. The issues that are consulted by patients involve healthcare problems, medications, usage of a medication, adverse affects. Pharmacists do not get paid for consultancy. Therefore, some issues besides health problems and medications are being consulted to pharmacists. Researches show that personal, family matters, political problems, asking for an address, lost property, elderly care and choice of profession are the most common issues that are asked. In that study for feeling good in daily life the roles and importance of pharmacists will be discussed. As a result, pharmacists are known as the most reachable consultant of the public. They find solutions to the problems of them. Pharmacists always find themselves well-informed and eager for meeting the demand. If they do not feel themselves sufficient, they can reach required sources.

Poster 20

Prof. Dr. Michael Schulz, Gianfranco Zuaboni, Michael Löhr, Rüdiger Noelle

Evaluation of a recovery-oriented Training program in Germany and Switzerland

This study investigates the effectiveness of a recovery-oriented training program on knowledge and attitudes of mental health care professionals towards recovery of people with serious mental illness. The Duration of the Training took six days. Users were part of the teaching team.

Method

Using data from a longitudinal study of recovery, changes in knowledge and attitudes of mental health care professionals from six training courses in Germany and Switzerland towards recovery were explored using translated versions of the Recovery in practice Evaluation tool (Gordon, 2010) Recovery Self Assessment - revised (O'Conell et al 2007). Measurements were taken before and after Training. With the intention to get a deeper understanding of the impact of training, the results of focus group interviews were included.

Results

This study shows that professionals' attitudes towards recovery from mental illness can improve with training.

Conclusion

A recovery-oriented training program can change attitudes of mental health care professionals towards recovery of serious mental illness. Mental-Health Professionals and Users were very impressed of the involvement of experienced involvement into that training program.

Poster 21

Ruth Chandler, Simon Bradstreet, Mark Hayward

Voicing Caregivers Experiences: Wellbeing and Recovery Narratives for Caregivers

Voicing Caregivers Experiences offers resources for all interested to consider recovery for caregivers alongside and distinct from the person cared for within the triangle of care. As a collaboration between Sussex Partnership Foundation Trust and The Scottish Recovery Network, we built on previous projects which identified the overlooked question of recovery for caregivers and a sense of 'merged narrative' for caregivers that often placed their wellbeing second to the person cared for. Authors set the agenda to develop a resource to support recovery for individual caregivers, to share knowledge with service providers and to influence key mental health decision makers

Method

A Life Story Work approach was used with caregivers with positive and negative experiences to develop narratives exploring recovery. The collection process prompted reflection from the editors on the positioning of caregivers within the triangle of care which was included as a separate section. Authors were given opportunities to take back or revise their narrative before publication, to collectively edit the manuscript and contribute learning points which framed the thematic content. *Results*

Views on recovery ranged from highly relevant and meaningful to irrelevant and insulting. Key themes were care for self, early support, relationships with services and shared humanity. The question of recovery from what and a focus on wellbeing emerged throughout the writing. Authors also placed a high emphasis on person-centred clinical care as key to recovery.

Discussion

Most authors struggled with seeing recovery and wellbeing as distinct from the person cared and this was difficult for long term caregivers. Most accounts suggested that an early focus on their recovery or wellbeing alongside the person cared for was more acceptable. Although authors spoke of hopeless relationships with services they also pointed to hope

inspiring ones and the importance of training to promote shared humanity.

Poster 22
Shinsuke Koike, Sosei Yamaguchi, Yasutaka Ojio, Shuntaro Ando
The effect of nominal change for schizophrenia from 'mind-split-disease' to 'Integration disorder' in Japan: a preliminary survey in university students

In Japan, the old term of schizophrenia, mind-split disease 'Seishin-Bunretsu-Byo'), renamed to integration disorder ('Togo-Shitcho-Sho') in 2002, and the term of dementia 'Chiho' to 'Ninchi-sho' in 2004 to reduce stigma. However, little has unknown how adolescents in present feel about the nominal changes.
Method
Total 148 students (male = 86, age = 20.3) answered anonymous self-administered questionnaires and quiz. The questionnaires contained the social recognition subscale of the Mental Illness and Disorder Understanding Scale (MIDUS) as positive knowledge, and Omnibus Survey in the UK, 1998, as negative knowledge, for the old and new terms of schizophrenia, depression, and diabetes mellitus. The quiz was instructed to choose the same disease and condition from 10 terms including 2 target terms of mental illnesses (schizophrenia [old and new] and dementia [old and new]), 3 mental illnesses and condition, and 3 physical illnesses and conditions.
Results
The significant difference of stigma among disease names (schizophrenia old, schizophrenia new, depression, and diabetes millitus) showed that the participants had the worst stigma for the old term of schizophrenia, similar for the new term of schizophrenia and depression, and the best for diabetes mellitus. The accurate rate of the quiz for schizophrenia and dementia was significantly different (45% vs. 91%, $p < .001$). Correct responders was significantly older (20.5 vs. 20.1, $p = .045$) and have marginally better positive knowledge trend for mental illnesses than incorrect responders (MIDUS: 17.7 vs. 19.8, $p = .050$).
Discussion
This is the first survey which explored the effect of nominal change for schizophrenia after 12 years in general adolescents. Although the terms of mental illnesses had more stigma than diabetes mellitus, the nominal change was successful in reducing stigma. The difference of the accurate rates for schizophrenia and dementia suggested little knowledge of mental illnesses in adolescence.

Poster 23
Steven Gillard, Sarah Gibson, Jessica-Rose Holley, Katherine Owen
New Ways of Working in Mental Health Services: a qualitative, comparative case study assessing and informing the emergence of new Peer Worker roles in mental health services in England

Peer workers are being introduced into mental health services in the UK in many settings. An international evidence base supports potential benefits of these roles and also cites some challenges around their introduction. We aimed to test evidence regarding barriers and facilitators for introducing Peer Worker roles into mental health services across England.
Method
A comparative case study design was employed across ten sites where Peer Worker roles had been introduced; 3 in the NHS, 4 in the voluntary sector, and 3 partnerships between the NHS and a voluntary sector or social care provider. At each site Service User Researchers interviewed Peer Workers, their co-workers, managers, strategic managers,

commissioners and service users supported by peer workers (N=91). Structured and in-depth questions enabled comparison of patterns across organizational contexts and development of in-depth understandings of processes. An interdisciplinary team of clinical, health services, organizational and service user researchers coproduced a complex analytical framework which integrated perspectives in the data.

Results

We found that many of the facilitators of Peer Worker role adoption in the literature were evident across mental health services in England. In the voluntary sector, introduction of Peer Worker roles was facilitated by flexible organisational structures and by underpinning organisational peer support ethos. Existing NHS structures and some lack of awareness and shared understandings of the role presented challenges. Peer Workers were best able to outwork their distinctive practice in partnership contexts though working across different organisational cultures is challenging.

Discussion

Introducing Peer Worker roles into mental health services is facilitated by developing shared understanding the essence of the Peer Worker role and valuing what is distinctive, actively supporting peer identity in the role and then addressing a range of organisational change issues, evolving structures, challenging boundaries and changing conversations and then ultimately the culture of services themselves.

Poster 24

Tom Barker, Pete Jordan, Rachel Crowe

Implementation of a Pilot Peer Support Worker (PSW) Service: Service User, Peer Support Worker and Staff perceptions and experiences

The introduction of peer support is a key driver of recovery orientated organisational change within NHS mental health services. This poster reports on the implementation of a pilot PSW service based on an acute in patient ward in Worcestershire. Although a small scale initiative, the PSW pilot has made a significant impact on the service within a short time frame.

Method

Qualitative data were collected from staff working in the host service and peer support workers via online questionnaires administered at outset, 3 months and are scheduled to be repeated at year end in October 2014. A focus group interview was also conducted with the PSWs three months into the pilot. Service user feedback has been collected using a Satisfaction questionnaire. These data collection methods have enabled triangulation of the experiences and views of staff, PSWs and service users.

Results

The qualitative data collected at different stages of the pilot service provide an interesting insight into: The significant challenges both for PSWs and staff members and also the huge benefits arising from the introduction of peer support. The personal impact on PSWs both positive and negative and essential structures needed to support coping. Service user feedback on the introduction of peer support.

Discussion

The lessons learned regarding successful implementation of peer support are discussed. The key issues which have emerged include preparation of the host team for peer support, supporting the integration of peer support within the service, and the need to support the resilience as PSWs who are introducing a different paradigm of care.

Poster 25
Tom Vansteenkiste
Images of Recovery: a participatory study through PhotoVoice

The concept of recovery is nowadays an important framework within mental health care in Belgium. This study focuses on the exploration of significance and perceptions of recovery through use of the visual methodology of PhotoVoice. By taking photographs, participants with ongoing mental health problems represent what they find important concerning personal recovery and well-being. A first PhotoVoice group of 8 participants started in Fall 2013. A second group is starting up in Spring 2014. *Method*
Within a qualitative research design, PhotoVoice as a participatory method is used. Participants are entrusted with cameras to document their lives. During 9 group sessions, participants are encouraged to use the power of visual images and narratives to communicate their life experiences and engage in critical reflection on themes of recovery and well-being. In addition, each participant is invited to a semi structured interview, in which personal views on recovery are explored.
Results
Analysis of the produced images is done participatory within the group. First findings show a visual representation of the importance of connectedness, spirituality and identity, meaningful activities and significant locations. Thematic analysis of the interviews suggest topics that can be described as feeling connected, personal growth, leading a normal life and being treated respectfully.
Discussion
Using PhotoVoice as a participatory method is very strong towards the exploration of everyday realities in recovery. Due to the constant interaction in the sessions, and the possibility to express oneself in a more visual manner, participants feel very involved. The use of visual images both on an individual and group level enhances the communication and reflection on the significance of recovery, especially for people who lack verbal fluency. People with ongoing mental health problems are able to show in a more direct way what is meaningful and supportive in their life and recovery journey.

Poster 26
Irene Wormdahl, Marit Borg, Bengt Karlsson, Turid Møller Olsoe
Recovery-oriented practices

The poster will describe a report published by the Norwegian Resource Centre for Community Mental Health recently about Recovery-oriented practices. The report summarizes the research literature of recovery, and aims to answer the following questions: How is recovery described? What characterizes recovery-oriented practices? What helps and hinders these practices? Are there any good examples of common recovery education programs for users and professionals, or evaluation methods? The report can be useful for professionals in the clinical practice of community-based mental health. Professors Marit Borg and Bengt Karlsson from Buskerud and Vestfold University College in Norway are the authors behind the report, which was initiated and commissioned by the Norwegian Resource Centre for Community Mental Health.

Poster 27
Zivile Jakaite, Charley Larkin, Beate Schrank, Mike Slade
Mental health service user experience of positive psychotherapy: WELLFOCUS PPT

WELLFOCUS PPT is a manualised group positive psychotherapy intervention for people with psychosis comprised of 11 weekly sessions. The sessions focus on savouring, gratitude, forgiveness, identifying good things and strengths. WELLFOCUS PPT was tested in a pilot randomised controlled trial. The aim of this study was to investigate service user perceptions of the helpfulness of therapy components in a positive psychotherapy intervention.

Method

Interviews and focus groups were conducted with participants who had received at least one session of WELLFOCUS PPT (N= 35, 17 female, mean age: 45.2 (S.D. = 10.5)]. All interviews and focus groups were audio recorded and transcribed with transcripts coded both deductively and inductively. For ease, the resulting framework was developed in a series of Excel spreadsheets. Because of the subjective nature of qualitative research and the subject matter, a mainly descriptive rather than interpretative method of analysis was used.

Results

Service users held favourable views of WELLFOCUS PPT. Key advances triggered by the therapy included service users' encouragement to consciously notice positive things in their life; learning how to savour experiences; identifying, developing and using personal strengths; realising the positive aspects of forgiveness; peer discussion; and therapist self-disclosure. Based on the positive changes effected by WELLFOCUS PPT, two service users reported to have been able to resume paid and voluntary work.

Discussion

The results of this study suggest that positive psychology exercises are well received and also useful for people with psychosis. This study provides guidance to clinicians in deciding whether to include one or more of the described components in either positive psychotherapy interventions or more traditional types of therapy such as CBT.