# Refocus on Recovery 2017



## 18 to 20 September 2017

## Nottingham Conference Centre, Nottingham, UK

Join the conversation **#RonR2017**

Web: **researchintorecovery.com**

the institute of mental health Nottingham

MAKING waves
challenging ideas about madness

ImROC
Implementing Recovery through Organisational Change

Mental Health Foundation

NHS
Nottinghamshire Healthcare
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The University of Nottingham
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# *Refocus on Recovery 2017*

## Expert workshops

## Programme

## Monday 18 September 2017

| 8.00am | *Registration opens for Expert Workshops* | | |
|---|---|---|---|
| | **Facilitator** | **Title** | **Room** |
| 9.00am-12.00noon | Julie Repper<br>Michael Ryan | Developing a national transformation programme | LT1 |
| | Mark Brown | Co-production of digital interventions | LT6 |
| | Helen Cyrus-Whittle | Coaching for recovery | LT7 |
| | Julie Gosling<br>Paul Atkinson | Drums and spears – Decolonising recovery | LT8 |
| | David Crepaz-Keay<br>Jayasree Kalathil | Building on cultures of peer support | LT9 |

# *Refocus on Recovery 2017*

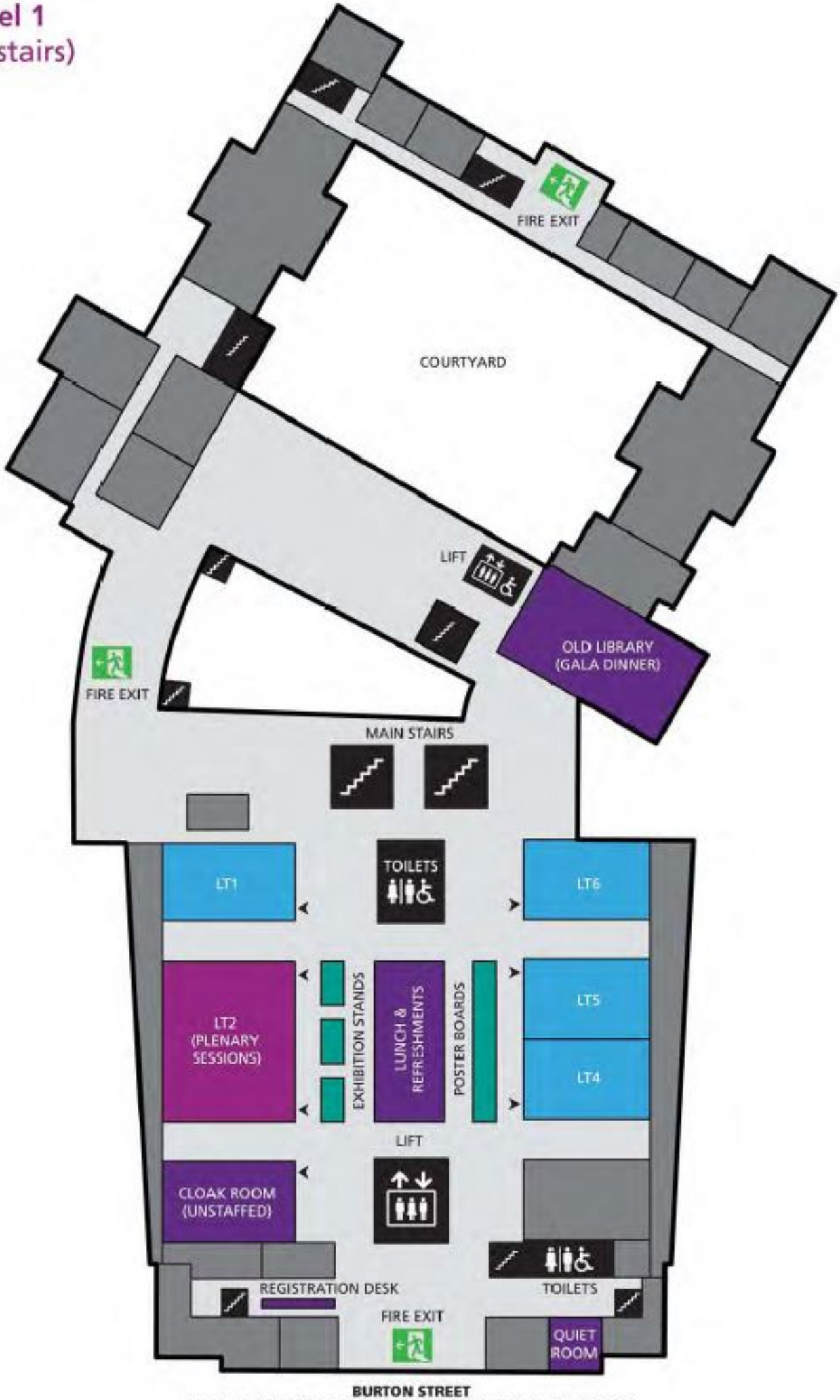
## Summary Programme

| **Monday 18 September 2017** | | | | | |
|---|---|---|---|---|---|
| 10.00am | *Registration opens* | | | | Registration desk |
| 1.00pm | Welcome: Sheriff of Nottingham, Ruth Hawkins, Jenny Edwards<br>People's Choir<br>Keynotes: Steve Gillard, Mark Hopfenbeck | | | | LT2 |
| 3.00pm | *Refreshments, poster viewing, The Mad Space* | | | | |
| 3.30pm-5.00pm | Parallel Session 1 | | | | |
| | Session 1.1<br>LT2 | Session 1.2<br>LT5 | Session 1.3<br>LT4 | Session 1.4<br>LT1 | Session 1.5<br>LT6 |
| 5.15pm | Keynote: Mike Slade | | | | LT2 |
| 6pm | *Drinks Reception (included in registration)* | | | | Central Gallery |

| **Tuesday 19 September 2017** | | | | | |
|---|---|---|---|---|---|
| 9.00am | Keynotes: Jayasree Kalathil, Isabella Goldie | | | | LT2 |
| 10.00am | Parallel Session 2 | | | | |
| | Session 2.1<br>LT2 | Session 2.2<br>LT5 | Session 2.3<br>LT4 | Session 2.4<br>LT1 | Session 2.5<br>LT6 |
| 11.00am | *Refreshments, poster viewing, The Mad Space*<br>Story shop drop in 10.30am-13.30pm | | | | |
| 11.30am | Parallel Session 3 | | | | |
| | Session 3.1<br>LT2 | Session 3.2<br>LT5 | Session 3.3<br>LT4 | Session 3.4<br>LT1 | Session 3.5<br>LT6 |
| 12.30pm | *Lunch, conference reflection session, poster viewing, The Mad Space* | | | | |
| 1.30pm | Boomwhacker event | | | | LT2 |
| 2.00pm | Keynotes (Nicola Kay, Manoj Kumar) | | | | LT2 |
| 3.00pm | *Refreshments, poster viewing, Our Mad Space* | | | | |
| 3.30pm | Parallel Session 4 | | | | |
| | Session 4.1<br>LT2 | Session 4.2<br>LT5 | Session 4.3<br>LT4 | Session 4.4<br>LT1 | Session 4.5<br>LT6 |
| 5.00pm | *End of day* | | | | |
| 7.00pm | *Conference dinner (optional extra)* | | | | |

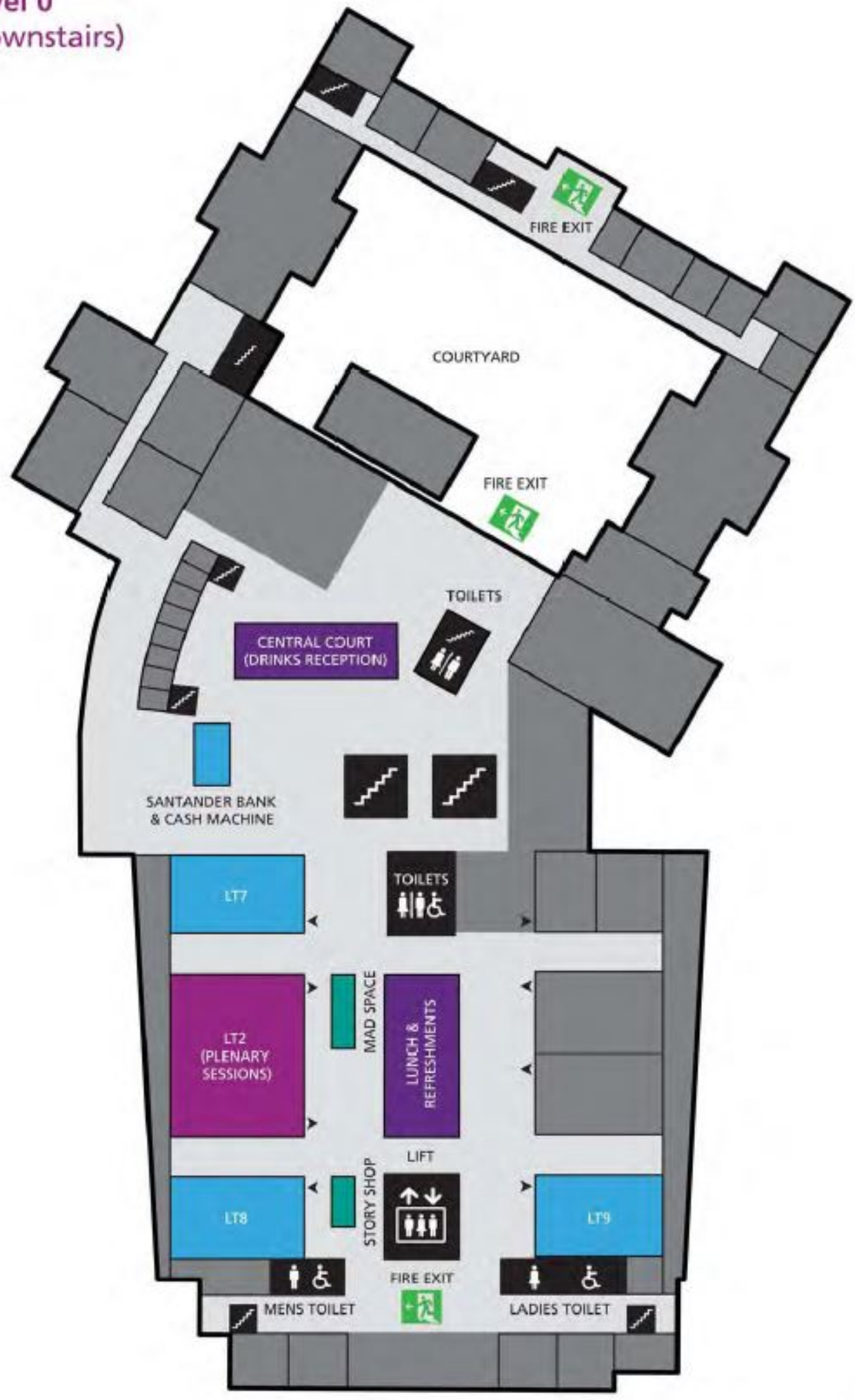
| **Wednesday 20 September 2017** | | | | | |
|---|---|---|---|---|---|
| 9.00am | Keynotes (Jasna Russo, Kwame McKenzie) | | | | LT2 |
| 10.00am | *Refreshments, poster viewing, The Mad Space* | | | | |
| 10.30am | Parallel Session 5 | | | | |
| | Session 5.1<br>LT2 | Session 5.2<br>LT5 | Session 5.3<br>LT4 | Session 5.4<br>LT1 | Session 5.5<br>LT6 |
| 12.00noon | Debate: 'This house believes that peer support should be an accredited mental health profession' | | | | LT2 |
| 12.45pm | Closing remarks | | | | LT2 |
| 1pm | *Conference ends* | | | | |

## Level 1
(upstairs)




**BURTON STREET**
**MAIN ENTRANCE TO CONFERENCE (WITH DISABLED ACCESS)**

## Level 0
(downstairs)



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| 108 | Certificate of attendance |

## Welcome to the *Refocus on Recovery 2017* conference

The aim of the conference is both to advance the field of recovery research and to create an international community of influence. The conference will bring together leading researchers and people who use mental health services, their carers and informal supporters, mental health workers and professionals, and policy-makers and other stake-holders from across mental health services and wider systems.

The conference has four themes.

**Theme 1: Recovery for different groups**
The meaning of, and support for, recovery in long-term conditions (physical and mental). Recovery in marginalised groups, e.g. culturally-sensitive services. Understanding and supporting recovery in mental health systems, e.g. Open Dialogue, REFOCUS, Individual Placement and Support. Organisational and individual influences on Peer Support Workers, including the meaning of 'peer'.

**Theme 2: Re-situating recovery**
Engaging with culture and community to make recovery a reality. Mainstreaming recovery, and links with other community initiatives, e.g. dementia-friendly communities. The role of family and supporters – what is a family in recovery? Improving access, e.g. digital interventions. Recovery Colleges as a bridge between mental health system and community. Insights from MAD Studies about recovery.

**Theme 3: Prevention of mental ill-health**
Supporting the development of resilience in individuals and communities. Creating inclusive communities. Inter-sectoral understandings of stigma and discrimination. National and local anti-stigma campaigns. Supporting self-management, including peer-led approaches. The role of inter-dependence. The impact of language and embedded assumptions. Developing new narratives, e.g. Mad lit, Photovoice.

**Theme 4: Allocating resources**
How money is spent, and with what effect. Service models and structures which foster or hinder recovery. Co-production and co-development approaches. The role of volunteers. Providing services in resource-poor settings. The contribution of health and social policy to recovery. The impact of legislation and commissioning arrangements.

We hope that you enjoy the conference!

## Acknowledgements and thanks

*Refocus on Recovery 2017* is organised by the Recovery Research team at the Institute of Mental Health in Nottingham. We are very grateful to our partners who have made the event possible:

- Nottinghamshire Healthcare NHS Foundation Trust
- School of Health Sciences, University of Nottingham
- Making Waves
- Mental Health Foundation
- ImROC

The Scientific Advisory Board was responsible for scientific aspects:

- David Crepaz-Keay (Mental Health Foundation)
- Julie Gosling (Making Waves)
- Julie Hankin (Nottinghamshire Healthcare NHS Foundation Trust)
- Binta Jammeh (Making Waves)
- Julie Repper (ImROC)
- Mike Slade (Institute of Mental Health / School of Health Sciences)
- Theo Stickley (Institute of Mental Health / School of Health Sciences)

The Local Organising Committee was responsible for logistics:

- Carole Appleby (Institute of Mental Health)
- Sarah Baily (Institute of Mental Health / School of Health Sciences)
- Sarah Gallivan (Institute of Mental Health)
- Ryan Knight (Nottinghamshire Healthcare NHS Foundation Trust)
- Mike Slade (Institute of Mental Health / School of Health Sciences)
- Karen Sugars (Institute of Mental Health)
- Rebecca Toney (Institute of Mental Health / School of Health Sciences)
- Anne-Marie Turney (School of Health Sciences)

We thank all the volunteers (they're the ones in purple T-shirts!) who have helped with running the conference.

We are very grateful for the financial support we received from:

- Nottinghamshire Healthcare NHS Foundation Trust
- School of Health Sciences, University of Nottingham
- Capital One

University of Nottingham
UK | CHINA | MALAYSIA

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

# Finding your way around

## Check out the Conference Centre maps on pages 3 and 4

The Conference Centre is on two floors – level 1 (main entrance) and level 0 (ground floor). There are ample lifts as well as stairs. Fire exits are clearly signposted within the building and on the Conference maps. Toilet locations are also shown on the Conference maps.

**Need to know anything?**
If you have any questions please go to the registration desk or just ask one of our volunteers – the people in the purple T-shirts.

**Refreshments**
All refreshments will be served both on Level 0 and Level 1 at the times shown in the programme.

**Cloakroom (Level 1 – close to registration desk)**
Coats and luggage can be left in an un-staffed cloak-room (room LT3) throughout the conference.

**The MAD Space (Level 0)**
The MAD space is continuous throughout Refocus on Recovery. It is hosted by OPEN FUTURES, Making Waves and Nottingham MAD Network - all lived experience-led initiatives and collectives. Lived experience displays, spontaneous interval presentations and representatives from local survivor organisations will welcome you to stop by and engage with some moments of MADness.

**Evening reception – Monday 18 September, 6pm (Level 0)**
Everyone is welcome to join us for a drinks and canapés reception in the Central Court (Level 0) on the evening of 18th September. This is included in the conference registration fee, and you will have the opportunity for relaxed networking with colleagues.

**Story Shop – Tuesday 19 September, 10.30am-1.30pm (Level 0)**
The Story Shop offers a chance to have a conversation with people with a range of stories across mental and physical health, on topics like bi-polar, schizophrenia, depression, substance misuse, psychosis and long term physical health issues such as diabetes and stroke. Ask someone to share their personal experience of mental or physical health. Find out more in an informal and relaxed way.

**Gala Dinner – Tuesday 19 September, 7pm (Level 1)**
The Conference Gala Dinner will take place in the Old Library (Level 1) at the Nottingham Conference Centre. The evening will commence with a glass of sparkling wine followed by a three course meal. The dinner is **not** included in the conference registration fee, and you will need a dinner ticket. If you want to come and have not bought a ticket please ask at the registration desk.

**Quiet room (Level 1)**
If you need time out from the conference there is a quiet room for people to drop in for some space and quiet. The room is open throughout the conference – feel free to use it whenever wanted. You can find the Quiet room near to the Main Entrance (see map). There is also a facilitated session in the Quiet room to help you reflect on the conference experience, during the lunch break on Tuesday 19 September.

**Prayer rooms**
Prayer rooms are located in the DiCe Building, rooms 020 and 021. The DiCe building is a 7-8 minute walk from the Conference building and any delegates requesting use of the prayer room will be directed there by Nottingham Trent University staff. Ask at the registration desk.

**Banking facilities (Level 0)**
Santander Bank is open Monday and Tuesday from 10 am – 6 pm and on Wednesday from 10 am until 5 pm. A cash point is also available in the Conference building (see map: GB £ sterling only).

# Nearby restaurants and cafés

**The Cornerhouse,**
Burton St, Nottingham NG1 4DB
https://cornerhousenottingham.co.uk/
This is a large complex very near the conference centre, with numerous restaurants:

- **Wagamama**
- **TGI Fridays**
- **Nando's**
- **Rocket at Saltwater**
- **Turtle Bag**
- **Tamatanga**
- **World Cuisine Buffet**
- **Pizza Hut**
- **Subway**
- **Bella Italia**

**Chunky Chicken**
1a, 30 Shakespeare St, Nottingham NG1 4FQ, UK
+44 115 837 3404
www.chunkychicken.com

**Creams**
Trinity Place, Burton St, Nottingham NG1 4BJ, UK
+44 115 941 8333
www.creamscafe.com

**Marco Pierre White Steakhouse Bar and Grill**
33 Wollaton St, Nottingham NG1 5FW, UK
+44 115 872 0602
www.mpwnottingham.com

**Prezzo**
21-23 Forman St, Nottingham NG1 4AA, UK
+44 115 941 4798
www.prezzorestaurants.co.uk

**Spanky Van Dyke's Eatery and Fun House**
17 Goldsmith St, Nottingham NG1 5JT, UK
+44 115 924 3730
www.spankyvandykes.com

**Tesco Express (small supermarket - will have inexpensive sandwiches)**
2, 24-30 Shakespeare St, Nottingham NG1 4FQ, UK
+44 345 671 9329
www.tesco.com

# Locations of restaurants and cafés near Nottingham Conference Centre

***Refocus on Recovery 2017***

**Detailed programme**

| **Monday 18 September 2017** | | | | | | |
|---|---|---|---|---|---|---|
| **10.00am** | ***Registration opens*** | | | | | |
| 1.00pm | **Chair: David Crepaz-Keay**<br>**Welcoming speeches:**<br>**Sheriff of Nottingham**<br>**Ruth Hawkins** (Nottinghamshire Healthcare NHS Foundation Trust)<br>**Jenny Edwards** (Mental Health Foundation) | | | | | LT2 |
| 1.40pm | **People's Choir** | | | | | |
| 2.00pm | **Steve Gillard** – Peer support in mental health services: social intervention or 'freedom to be'? | | | | | |
| 2.30pm | **Mark Hopfenbeck** – Peer-supported open dialogue: On Recovering Difference | | | | | |
| **3.00pm** | ***Refreshments***<br>***Poster viewing***<br>***The MAD Space*** | | | | | |
| 3.30pm-5pm | **Parallel Session 1** | | | | | |
| | **Session 1.1**<br>**LT2**<br>Theme: Re-situating recovery<br>Chair: Steve Gillard | **Session 1.2**<br>**LT5**<br>Theme: Recovery for different groups<br>Chair: David Rosenberg | **Session 1.3**<br>**LT4**<br>Theme: Recovery for different groups<br>Chair: Jon Arcelus | **Session 1.4**<br>**LT1**<br>Theme: Prevention of mental ill-health<br>Chair: Noushig Nahabedian | **Session 1.5**<br>**LT6**<br>Theme: Allocating resources<br>Chair: Gianfranco Zuaboni |
| | **Julie Gosling**<br>Lived experience is more than service user porn! Creation of an online resource for mental health nurse students | **Agnes Higgins**<br>Supporting recovery through co-facilitated programmes: The EOLAS Programmes | **Joeri Vandewalle**<br>"Constructing a positive identity": A qualitative study of the driving forces of peer workers in mental health care systems | **Tom Vansteenkiste**<br>PhotoVoice: Using the power of visual narratives to explore personal recovery in mental health | **Ashley-Christopher Fallon**<br>"My recovery journey, with me in the driver's seat" – helping forensic service users engage with the service model |
| | **Steve Gillard**<br>Co-production, lived experience and large multidisciplinary teams: making it meaningful in practice | **Rebecca Murphy**<br>Restoring meaning to asylum seekers' lives in Ireland; the key to their mental health recovery? | **Bart Debyser**<br>The transitional process from mental health patient to mental health peer worker: exploring the underlying dynamics | **Mary Birken**<br>Assessment of a framework focusing on time-use, activity and participation to promote mental health and well-being | **Tanya Samuels**<br>Exploring the potential to develop different service models to support people in mental health crisis |

| | | | | | |
|---|---|---|---|---|---|
| | **Roberta Casadio**<br>Developing a Whole Life Recovery Community and Recovery House in Trieste, Italy | **Frank Keating**<br>Socially oriented approaches to recovery for African and Caribbean men: some preliminary findings | **Joeri Vandewalle**<br>Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review | **Catherine Winsper & Anne Crawford Docherty**<br>Understanding mechanisms of change underpinning interventions for sustainable recovery in mental illness: A realist logic model systematic review | **Rose Thompson**<br>Implementing independent support brokerage and personalised support planning in traditional social care settings: lessons learned in a local council context |
| | **Kristin Ørjasæter**<br>I've got a life. Negotiating meaning in participatory arts | **David Rosenberg**<br>The effects of peer support workers on psychiatric environments – recovery orientation as outcome | **Bart Debyser**<br>Mental health nurses and mental health peer workers: self-perceptions of roles and clinical competences | **Noushig Nahabedian**<br>Coaching conversations for recovery | **Li-yu Song**<br>The usefulness of the strengths model in facilitating recovery: the participants' perspective |
| | **Simone Arbour**<br>The implementation and impact of a recovery college at a tertiary mental health hospital in Canada | **Leora Pinhas**<br>Recovery High School: adapting recovery model for an adolescent inpatient unit | **Bart Debyser**<br>The formal training of mental health peer workers in Flanders: a practical example | **Stephanie de la Haye**<br>Beyond policy – a real life journey of engagement and co-production to aid the recovery journey | **Mathilde Labey**<br>Health democracy and recovery oriented practices: a French experience in mental health |
| **5.15pm** | **Chair: Gabrielle Richards**<br>**Mike Slade – New frontiers in recovery research** | | | | **LT2** |
| **6pm** | ***Drinks Reception (included in registration)*** | | | | **Central Court (Level 0)** |

| Tuesday 19 September 2017 | | | | | |
|---|---|---|---|---|---|
| 9.00am | **Chair: Graham Meadows**<br>**Jayasree Kalathil** | | | | LT2 |
| 9.30am | **Isabella Goldie** – Surviving or Thriving: creating a movement for change | | | | LT2 |
| 10.00am-11.00am | **Parallel Session 2** | | | | |
| | **Session 2.1**<br>**LT2**<br>Theme: Recovery for different groups<br>Chair: Sharon Gilfoyle | **Session 2.2**<br>**LT5**<br>Theme: Recovery for different groups<br>Chair: Mary Birken | **Session 2.3**<br>**LT4**<br>Theme: Re-situating recovery<br>Chair: Anna Taylor | **Session 2.4**<br>**LT1**<br>Theme: Prevention of mental ill-health<br>Chair: Shulamit Ramon | **Session 2.5**<br>**LT6**<br>Theme: Allocating resources<br>Chair: Vrinda Edan |
| | **Sally Barlow**<br>Barriers to and facilitators of recovery-focused care planning and coordination in UK mental health services: findings from COCAPP and COCAPPA | **Corinna Hackmann**<br>Attachment in mental health peer support: A realist review perspective | **Samantha Adkins**<br>Understanding the 'layers' of recovery education | **Kate Nurser**<br>A qualitative exploration of 'Telling My Story' in mental health recovery | **Rebecca Murphy**<br>Peer-led mental health support in Ireland: Delivering on personal and clinical recovery |
| | **Lea Gaulshøj Thomsen**<br>How to deal with sleeping difficulties when this is only one difficulty among many | **Sandra Jayacodi**<br>CNWL's SHINE Project: Working with service users to develop new approaches to physical health care in mental health services | **Louise Niven**<br>Adopting recovery orientated care in a small inpatient unit in the Kingdom of Saudi Arabia | **Shulamit Ramon**<br>Shared decision making as a co-produced preventive self-management strategy: A UK case study | **Vrinda Edan**<br>PULSAReveryday - a consumer led project |
| | **Carina Teixeira**<br>Peer support providers in the United States mental health services and systems | **Mary Birken**<br>Feasibility study of a recovery orientated intervention following discharge from hospital to promote participation in daily life | **Louise Hunt**<br>Running in the family | **Noami Hadas Lidor**<br>Training for shared decision making (SDM) as a co-production: An Israeli case study | **Caroline Clarke**<br>The challenge of developing recovery oriented services in secure settings: 'My Shared Pathway' as a framework |

| | | | | | |
|---|---|---|---|---|---|
| **11.00am** | ***Refreshments / Poster viewing***<br>***The MAD Space***<br>***Story shop drop in 10.30am-13.30pm*** | | | | |
| 11.30am-12.30pm | **Parallel Session 3** | | | | |
| | **Session 3.1**<br>**LT2**<br>Theme: Recovery for different groups<br>Chair: Elizabeth Hughes | **Session 3.2**<br>**LT5**<br>Theme: Recovery for different groups<br>Chair: Marissa Lambert | **Session 3.3**<br>**LT4**<br>Theme: Re-situating recovery<br>Chair: Helen Jennings | **Session 3.4**<br>**LT1**<br>Theme: Re-situating recovery<br>Chair: Rebecca Toney | **Session 3.5**<br>**LT6**<br>Theme: Prevention of mental ill-health<br>Chair: Laurie Hare Duke |
| | **Kelly Elsewood**<br>A novel and inexpensive approach to fostering hope for recovery for people with complex mental health difficulties using 'experts by experience' | **Fay Jackson**<br>"Why not a peer worker?" | **Julia Lowes**<br>“Spireites Active for Life” : Recovery & healthy lifestyle project in partnership with Chesterfield Football Club | **Simone Arbour**<br>The implementation and evaluation of a recovery-oriented practice training module for service providers at a tertiary mental health hospital in Canada | **Susan Hogan**<br>Mothers Make Art |
| | **Elizabeth Hughes**<br>"Sex - the elephant in the room" : Supporting and promoting sexual health in mental health recovery | **Mang Wun Hung**<br>Peer Mentor Program: An innovative recovery-oriented service for psychiatric patients in Hong Kong | **Mona Sommer**<br>Lived experiences of support in the lives of young people with mental health problems | **Ritsuko Kakuma**<br>The PULSAR Project: What is the cross-cultural relevance of a mental health recovery questionnaire? | **Melissa Pyle**<br>Evaluation of peer support training: impact on empowerment and internalised stigma |
| | **David Rosenberg**<br>Obstacles and possibilities for implementing SDM in Swedish mental health services; Supporting interactivity & participation | **Wing Kin Siegfrid Lee**<br>Recovery-oriented practice in Occupational Therapy | **Hilda Näslund**<br>The role of mental health service user organisations in the post-deinstitutional era – a narrative lit review | **Rebecca Toney**<br>Development and evaluation of a fidelity measure for Recovery Colleges | **Laurie Hare Duke**<br>Towards a conceptual framework of belonging: a systematic review of measures |
| ***12.30pm*** | ***Lunch***<br>***Conference reflection session (Quiet room, 12.30pm-1.30pm)***<br>***Poster viewing***<br>***The MAD Space*** | | | | |
| 1.30pm | Well-being event with Boomwhackers | | | | LT2 |
| 2.00pm | **Chair: Stynke Castelein**<br>**Nicola Kay** – A personalised approach to mental health: how to get person-centred, integrated and better value services | | | | LT2 |
| 2.30pm | **Manoj Kumar** – The feasibility of mental healthcare delivery by volunteers in a co-production model of mental health care delivery in resource-scarce settings | | | | LT2 |

| **3.00pm** | ***Refreshments***<br>***Poster viewing***<br>***The MAD Space*** | | | | |
|---|---|---|---|---|---|
| 3.30pm-<br>5.00pm | **Parallel Session 4** | | | | |
| | **Session 4.1**<br>**LT2**<br>Theme: Re-situating recovery<br>Chair: Graham Meadows | **Session 4.2**<br>**LT5**<br>Theme: Recovery for different groups<br>Chair: Chiara Samele | **Session 4.3**<br>**LT4**<br>Theme: Re-situating recovery<br>Chair: Theodore Stickley | **Session 4.4**<br>**LT1**<br>Theme: Recovery for different groups<br>Chair: Phil Morgan | **Session 4.5**<br>**LT6**<br>Theme: Allocating resources<br>Chair: Simon Riches |
| | **Graham Meadows**<br>Principles Unite Local Services And Recovery (PULSAR): Introduction and overview | **Niamh Bergin**<br>Does recovery CHIME with carers: A qualitative analysis of carers' experiences of personal recovery | **Giovanni Grassi**<br>From secure forensic mental health services to community services: Utilizing the Tree of Hope | **Eva Brekke**<br>Strengthening recovery orientation of services for persons experiencing co-occurring mental health and substance use conditions | **Pooja Pillai**<br>'Pictures make it easy' – co-development of a visual tool for recovery in North India using participatory action research |
| | **Vrinda Edan**<br>PULSAR Recovery orientated practice, the intervention | **Qi Wang**<br>The role of spirituality in the process of recovery from traumatic experiences - A qualitative research | **Stynke Castelein**<br>Boost Recovery: Implement Resource groups in mental health care?! | **Alie Weerman**<br>Disclosure of personal experiences of social work professionals | **Simon Riches**<br>Social performance and paranoid ideation: using virtual reality to resituate recovery-focused interventions |
| | **Penny Weller**<br>Implementing PULSAR | **Susann Porter**<br>Critical factors for the return-to-work process among individuals with depression: voices from two vocational approaches | **Theodore Stickley**<br>The art of recovery | **Phil Morgan**<br>The impact of co-produced mental health training for paramedics | **James Wooldridge**<br>Recovery Devon Development Fund |
| | **Lisa Brophy**<br>PULSAR: Preliminary data | **Lianne Powell**<br>Reshaping lives: Supporting dual diagnosed service users to become their 'new me' | **Lucie Duncan**<br>Challenging the care planning process and improving quality | **Louise Canacott**<br>Recovery for women with borderline personality disorder in secure services | **Ian Henwood**<br>The benefits of co-production |

| | | | | | |
|---|---|---|---|---|---|
| | **Vrinda Edan**<br>Implementing recovery oriented practice in primary care – a case study within PULSAR | | **Katarina Grim**<br>Development- and usability testing of a web-based decision support for users and health professionals in psychiatric services | **Leila Persaud**<br>Factors which contribute to a successful recovery programme: Two case studies | |
| **5.00pm** | ***End of day*** | | | | |
| **7.00pm** | ***Conference Gala dinner (optional extra)*** | | | | |

<table>
<tr><th colspan="6">Wednesday 20 September 2017</th></tr>
<tr><td>9.00am</td><td colspan="4">Chair: Theodore Stickley<br>Jasna Russo – Connecting first-person knowledge of madness and distress: from individual stories to collective and inclusive epistemology</td><td>LT2</td></tr>
<tr><td>9.30am</td><td colspan="4">Kwame McKenzie – Building societies that promote recovery</td><td>LT2</td></tr>
<tr><td>10.00am</td><td colspan="5">Refreshments<br>Poster viewing<br>The MAD Space</td></tr>
<tr><td rowspan="4">10.30am<br>-12.00noon</td><td colspan="5">Parallel Session 5</td></tr>
<tr><td>Session 5.1<br>LT2<br>Theme: Recovery for different groups<br>Chair: Joanna Fox</td><td>Session 5.2<br>LT5<br>Theme: Recovery for different groups<br>Chair: Rebecca Toney</td><td>Session 5.3<br>LT4<br>Theme: Recovery for different groups<br>Chair: Katja Milner</td><td>Session 5.4<br>LT1<br>Theme: Recovery for different groups<br>Chair: Bridey Rudd</td><td>Session 5.5<br>LT6<br>Theme: Re-situating recovery<br>Chair: Helen Jennings</td></tr>
<tr><td>Joanna Fox<br>Reflections on developing a blended learning recovery education programme for mental health carers</td><td>Jojanneke Bruins<br>VOICE: Valuing Opinions In Communication Experiences in severe mental illness</td><td>Katja Milner<br>The role of spirituality in mental health and recovery</td><td>Michael Schwartz<br>Celebration Recovery: A decade of past celebrations in the US and a new global celebration coming in 2020 in France!</td><td>Daniela Sangiorgi<br>Designing for co-production: The case of developing a recovery approach in a mental healthcare service</td></tr>
<tr><td>Rhiannon Foster<br>Peer support, professionalisation and authenticity in mental health services: A Foucauldian perspective</td><td>Christine Wilson<br>Let's Talk! About psychological therapies in Wales</td><td>Chiara Samele<br>Supporting forensic mental health service users into employment and vocational activities: A pilot scheme</td><td>Ella Hancock-Johnson<br>Paid formal lived experience workers (LEWs) within a secure mental health service - their experiences</td><td>Kristin Ørjasæter<br>Transforming identities. Engaging in participatory arts for people with mental health problems</td></tr>
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|---|---|---|---|---|---|
| | **Stephanie Barker** Peer-support and helping the homeless: A qualitative study on critical elements and experiences of peer-supporters | **Fiona Ng** What goals do individuals with Borderline Personality Disorder have for treatment and recovery? | **Andrew Shepherd** Recovery within prison as a process of identity construction | **Bridey Rudd** Recovery and alcohol related brain damage | **Raphael Bouloudnine** Multi-counselling management as a practical response to recovery |
| | **Donal O'Keeffe** A meta-synthesis of service users' perceptions of the meaning of and influences on recovery in 'psychotic illness': Implications for research and practice | **Diana Byrne (Cunningham)** From ward to Board triumph over tragedy | **Lorna Loftus** 'Steps in Wellness' - A pilot group programme in a liaison psychiatry service | **Bridey Rudd** Using I.ROC to measure personal recovery in survivors of complex psychological trauma | |
| | **Joy Rooney** Patients' views of intentional mental health peer support | | | | |
| **12.00noon** | **Debate: 'This house believes that peer support should be an accredited mental health profession'**<br>**Chair: Glenn Roberts**<br>**For the motion: Vrinda Edan, Stynke Castelein**<br>**Against the motion: Graham Meadows, Karen Machin** | | | | **LT2** |
| **12.45pm** | **Closing remarks – Julie Repper** | | | | |
| **1pm** | **Conference ends** | | | | |

# SPEAKERS WELCOMING YOU TO NOTTINGHAM

**The Sheriff of Nottingham 2017/18, Councillor Glyn Jenkins**
Councillor Glyn Jenkins was first elected as Councillor for the Leen Valley ward in May 2011. Glyn is very honoured to be chosen as Sheriff of Nottingham for 2017/18 and is looking forward to serving the people of Nottingham as Sheriff.

**Ruth Hawkins** was appointed Chief Executive of the Nottinghamshire Healthcare NHS Foundation Trust on 1 November 2014. This followed eight years as the Trust's Director of Finance, and for six years its Deputy Chief Executive. Prior to joining the Trust, Ruth was a Director of Finance in the NHS in a number of organisations, including spells with an NHS Trust, a Health Authority and a Primary Care Trust.

Ruth has a BA in Public Administration and gained her chartered status with the Chartered Institute of Public Finance and Accountancy.

**Jenny Edwards** has been Chief Executive of the Mental Health Foundation since 2013. She has focused our work on the prevention of and early intervention in mental health problems. Under her leadership learning and best practice is shared by strengthened links between our teams in different parts of the UK. Jenny is a member of the Common Mental Health Disorders Expert Reference Group, the Ministerial Advisory Group on Mental Health and the Mental Health Policy Group. Previously, Jenny was Chief Executive of Homeless Link, the umbrella body for homeless charities. She chaired the Ministerial Advisory Group on Homelessness and the Mayor's Roundtable. Jenny was instrumental in founding the Making Every Adult Matter Alliance, focusing on the multiple needs of mental health, addiction, homelessness and offending. She was awarded a CBE in 2011 for her work.

Jenny was an expert advisor to Heriot Watt University's study of severe and multiple disadvantages in the UK, published as Hard Edges. She has also been a consultant to Government on approaches to multiple disadvantage and support for vulnerable people.

# EXPERT WORKSHOPS

## Expert Workshop 1: Developing a national transformation programme

### Facilitators: Julie Repper; Michael Ryan

**Julie Repper** is Director of ImROC. ImROC works in partnership with communities to develop systems, services and cultures that support recovery and wellbeing for all. Julie is also Recovery Lead at Nottinghamshire Healthcare Trust and Associate Professor of Recovery at University of Nottingham. She draws on her experience of working as a nurse, manager, researcher and lecturer, as well as her personal experience of using services, to support greater understanding of Recovery. She works across service boundaries with people who use services, providers, commissioners and academic institutions to support collaborative approaches in facilitating Recovery.

Julie has written widely and is co-editor of the Journal of Mental Health and Social Inclusion. She leads a Recovery Research work stream at the Institute of Mental Health and continues to undertake research and supervise research students through her work in the University. She continues to undertake research and supervise research students through her work in the University.

**Michael Ryan** is Director of Advancing Recovery Ireland a national Irish HSE initiative to develop more recovery orientated services through a partnership approach with those who use services and those who provide them. Michael has his own lived experience of mental health issues and now enjoys a full life in recovery. A strong believer in co - production as the key driver of developing a recovery culture in services, Michael has been instrumental in the mainstreaming of 'Peer support' Recovery Colleges and other recovery innovations as part of the Irish MHS. Michael is married with a family and lives on the shores of Clew bay in County Mayo.

**Abstract**

This workshop will describe the purpose and development of the ImROC (Implementing Recovery through Organisational Change) methodology and summarise its achievements, challenges and lessons learnt. It will be of relevance to delegates who have a national or regional role in commissioning, developing and/or delivering mental health services. Participants will work through a number of exercises to enable them to:

- Consider the relevance and purpose of a national programme in their own area/service
- Identify the key stakeholders to collaborate with in constituting a national programme
- Discuss the primary importance of coproduction and plan a strategy to achieve coproduction at every level of the programme
- Review the meaning and relevance of the ten organisational challenges in the context of the areas/services in which delegates' work.

## Expert Workshop 2: Co-production of digital interventions

**Facilitator: Mark Brown**

**Mark Brown** is development director of Social Spider CIC, ex-editor of One in Four magazine, one of Nursing Times/Health Service Journal Social Media Pioneers 2014, mental health writer, doer. One of the people behind the regular We Mental Health Nurses chats on twitter. Current digital projects: Leeds Mental Health and Wellbeing Innovation Lab, COOP CAMHS platform, A Day in the Life https://dayinthelifemh.org.uk/ and a development of A Day in the Life focused upon adult learners with mental health difficulties and an app to support advice seekers. Mark regularly writes and speaks on mental health and technology. Mark Brown is @markoneinfour on twitter.

**Abstract**

This workshop, delivered by Mark Brown, is for those wishing to explore practical techniques for developing digital mental health projects in co-productive and co-designed ways. It is intended for people who want to learn about practical nuts and bolts approaches to making mental health digital projects that people might actually like and use.

Mark will explore the techniques he uses in these situations and their implications and application.

The session will be interactive, discussion based and lively and attendees will go away with ideas and practical methods that will be possible to implement as part of their digital development projects.

## Expert Workshop 3: Coaching for recovery

**Facilitator: Helen Cyrus-Whittle**

**Helen Cyrus Whittle** has been a qualified Life Coach as well as an NLP Practitioner for 12 years. She was a qualified RN Nurse, and has worked at both the City and QMC in Nottingham. After which she went into Public Health, and then teaching in FE for a few years. Helen coaches individuals on a one to one basis, runs courses for mixed groups within the region, and abroad as well as seminars, staff development, and tailor made courses for organisations. Helen has a speciality interest in working within Mental Health and has for the last 8 years been running the Coaching Skills Courses in Recovery and Wellbeing with Nottingham Mental Health Trust and now the Partnership Staff. Enabling staff in using the approach to improve their skills in communication and create changes in their own lives as well as to motivate, empower and help clients to have a choice, become more motivated and to have their say in what they want in their lives and care. Helen was the local BBC resident Life Coach on Sun afternoons, for a year in 2007/8. She is passionate about what she does and enjoys coaching immensely. The aim of Helen's work is to help motivate individuals to believe in themselves, to discover their gift/ passion in life, and to do what they do well. By helping to build on their self worth and by understanding what makes them who they are!'

**Abstract**

This masterclass in Coaching for Recovery and Wellbeing will be a dynamic exciting three hours which will impact you in all areas of your life and will help to give you tools to practically go away with; to look at how you live and deal with life's situations as they arise and how you manage work and the people in your sphere of influence and concern.

'Coaching works on the basis that you already have the answers within and with the use of powerful questions the mind will come up with the correct answer. It looks at where you are now and where do you want to get to without focusing on the past'

That being the case this workshop will help you to learn to ask the right questions and how to begin becoming skilled in using this technique. It is known to help change mind-sets, behaviours and increase self-awareness and in turn create changes in the areas you most need it for your professional/work/life development.

- This workshop will endeavour to look at goal setting exercises.
- Different ways to communicate and demonstrations of how this can be effective in real life situations and therefore the dovetailing of the principles of recovery.
- Enabling you to look at what you want, and how to go about taking these steps to develop that change.
- To empower you to believe that you can change and plan the long term goals whilst making/seeing the progress in the mini stages to get there.

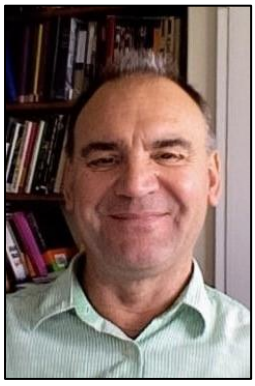
You may be the senior executive of a Trust or health organisation or someone who has lived experience, or a frontline worker.

The purpose of this masterclass workshop will be based around the practical application of using coaching tools and in so doing the understanding and principles to be able to use on yourself, with staff, clients or a management team.

## Expert Workshop 4: Drums and spears – decolonising recovery

**Facilitators: Julie Gosling; Paul Atkinson**

**Julie Gosling** is an older woman of Irish heritage. She identified as a survivor of child violence, domestic abuse and homelessness in a time when there were no services, and she now lives with their ongoing traumatic impact on her mental, spiritual and physical well-being. Julie has been an activist and educator for 30 years. Without formal health or social welfare qualifications, she was awarded in 2013 with an honorary doctorate for 'outstanding contribution' to international social work education. Julie is founder-director of Advocacy in Action which has since 1990, pioneered lived and peer experience nationally and globally in the education of social work and healthcare practitioners, in service-user-led research, and in quality assurance of those learning and research frameworks. In addition Julie founded and still volunteers in a benefits activism /advice group, FIANN. After suffering retirement for 3 months in 2012, she allowed herself to be pulled back in as Training Education and Research Lead for Making Waves and she now directs the Making Waves network in promoting lived experience and peer led action nationally. Appointed research fellow to the Institute of Mental Health in 2013, she has encouraged MAD studies and MAD activism regionally and she is particularly committed to involving the least well-heard voices within current mental health discourses. You can find lots more about Julie via her publications, media productions and projects by visiting her LINKED IN profile or by talking to her at Refocus On Recovery 2017.



**Paul Atkinson** has worked as a psychotherapist for more than thirty years, mainly in private practice in London. He was a political activist during the 1970s and in recent years has returned to campaigning politics - opposing state regulation of psychotherapy and counselling, supporting activists and organising psypolitical events at Occupy St Paul's, campaigning for the NHS in East London, running mens' therapy groups, and working with mental health activists against psycho-compulsion through DWP 'work cure' policies. He is a member of the Free Psychotherapy Network, the Alliance for Counselling and Psychotherapy, and Psychotherapy and Counselling for Social Responsibility.

**Abstract**

… we need a closer more informed relationship between the drums and spears … where the spears are rooted in the world of the drums … and if the drums no longer sound, we must beat them … and if we have no drums, we must build them … and if we have forgotten how to play them, we must remember or relearn … and if we can't renew our continuity with the past, then we must make a virtue of our discontinuity and make it all anew …

Drums or spears - culture versus conflict? There are challenges within both survivor and allied practitioner activism to the take-over and exploitation of recovery and of the lived experience communities who nurtured and protected its territory. The drums represent the rhythms of indigenous culture which, like a heartbeat, sustain resistance to colonisation. Decolonising Recovery considers how creating cultural resistance strategies is in the long

term more sustainable than tactics of direct conflict - although recognising that both have a place in our present refocus on recovery.

The context of this workshop plots mental health best practice in the roots of survivor / consumer theoretical modelling, innovation and activism, tracking the inception of person-centred practice, advocacy, peer support, personalisation, co-production and indeed recovery itself, from those grass root beginnings within the human lived experiences of mental distress and difference, through their co-option, incorporation and colonisation by institutions of health and welfare and the ultimate commodification within government policy as agents of psycompulsion and blame-shifting.

This workshop is a clarion call to all who are concerned by the impact of neoliberal colonisation and who wish to reclaim authenticity, integrity and agency through re-appropriating and radicalising mental health services, and renewed human relations rooted in compassion, collective well-being and the wisdom of personal lived experience. It will encourage participants to share dilemmas, validate achievements and together co-produce new and mutually healing strategies for rewarding relationships, sustainable best practice and survival within mental health and well-being provision.

In the present dismal climate of dismantled hopes and provision – and in true collaborative spirit - this workshop will gain from the participation of policy makers, managers, grass roots practitioners, service-users /carers - as community activists and change agents - drawing equally on professional and personal experience to co-construct dynamic and transformational frameworks for Recovery

The facilitators bring a wealth of activism and innovation from a range of pioneering initiatives, applicable to present mental health systems and networks. Offered are a range of specific skills, tactics and strategies that can be implemented immediately into everyday practice, planning and response within both existing provision and the co-production of new possibilities and that draw on cutting edge thinking within change-management, mad constructs, emergent experience economies, open dialogue, commons ideologies and peer-to-peer collaborations.

Some of the tactics explored will cover:

- Invisible bullets – the hidden power and possibility of language
- Gentle subversions - comedy, arts and humanities as freedom fighters
- Secret messages - narratives as testimonies of experience and cultural guardians
- Freedom fighters - activisms of personal pain and distress
- Agents of resistance and subversion - professional practice as insider activism
- Rules of exception - occupying policies, guidelines and legislation
- Borderlands, borderlines and alliances - re-routing disciplines, roles and boundaries
- Disruptive technologies – democratising knowledge and learning from experience
- United front - collective solidarity, mutual healing, commons and co-production

The drums and spears of decolonised recovery seek long term cultural sustainability alongside present challenge for positive change. Long then after spears have laid to rest, let the drums beat on

*… and may all that has been silenced … or reduced to noise within you … become music again …*

## Expert Workshop 5: Building on cultures of peer support

**Facilitators: David Crepaz-Keay; Jayasree Kalathil**

**David Crepaz-Keay** is Head of Empowerment and Social Inclusion at the Mental Health Foundation. A former economist, statistician and long term psychiatric patient, he has been developing, delivering and evaluating service user involvement in mental health and broader health. He was a founder member of NSUN, England's National Survivor User Network and established and co-facilitates the National Mental Health Forum for Wales; he spent seven years as commissioner on the board of the Commission for Patient and Public Involvement in Health and is an advisor to the World Health Organisation on empowerment. David led the development of mental health empowerment indicators for WHO Europe. He led the development and delivery of self-management and peer support for secondary mental health service users, single parents and prisoners. David has published widely on service user involvement, self-management and peer support.

**Dr Jayasree Kalathil** is an independent researcher, writer and mental health activist. Her work focuses on linking activism and mobilising user/survivor participation from marginalised and minoritised groups to influence knowledge production, policy and practice on issues of racialisation, gender and human rights in mental health. Her publications include a study of black women's narratives, Recovery and resilience (2011) and the co-authored book Values and ethics in mental health (2015). A special issue of Philosophy, Psychiatry & Psychology on mental health user/survivor research, co-edited with Nev Jones, is forthcoming in 2016. She has also published a children's book The Sackclothman (2009) and is currently working on a translated anthology of short stories from her mother tongue Malayalam into English, a project funded by the Thunchath Ezhuthachan Malayalam University, Kerala.

**Abstract**

Peer support is becoming recognised as having a significant contribution to ensuring sustainable approaches to community mental health. Done well, peer support builds on strengths, builds experience into expertise. Done badly, however, peer support can be seen as second rate nursing on the cheap and can tarnish peer relationships. This workshop will use international examples to:

- explore the nature of peer relationships
- identify ways of encouraging peer support to develop in different settings and communities
- identify blocks and challenges to authentic peer support and how to overcome them

# KEYNOTE SPEAKERS

**Steve Gillard** is Reader in Social and Community Mental Health in the Population Health Research Institute at St George's, University of London. His current research focuses on the increasing role played by people with lived experience of mental health problems in producing the support that they make use of - the development of more distributed forms of mental health care - including the introduction of new Peer Worker roles into mental health services. His research is underpinned by standpoint epistemology and co-production approaches to research; working alongside researchers with lived experience to critique and strengthen, methodologically, the way in which we produce knowledge about mental health.

## Peer support in mental health services: social intervention or 'freedom to be, chance to dream'?

**Abstract**
Peer support has been with us as long as people have shared their experiences of mental distress. People coming together to support each other in a more structured way isn't particularly new either, with an extended history of self-help groups of one sort or another. What is new(ish) is the introduction of peer support into mental health services, and especially the advent of the 'peer worker' role. There is compelling testimony to the benefits of peer support, but limited trial evidence of the effectiveness of these more organised approaches. We question whether we are measuring the right things in the right way, if we have managed to pin down what it is about peer support that brings about change.

Various efforts have been made to distil or define the values, principles or standards that differentiate peer support from other approaches to mental health support, and these endeavours can potentially help us improve evaluation. But this values work also suggests that some of what we do might NOT be considered peer support. If we formalise peer support in such a way that we can deliver and measure specified outcomes – if we turn peer support into an 'intervention' – are we are still doing peer support at all? Or is peer support by definition a space in which people are free to be and to aspire, unconstrained by the discourse and practice of psychiatry? And if the latter how do we measure whether peer support works? Or should we measure at all?

In considering some very different approaches to evaluating some very different approaches to peer support we can caution against the dangers of trying to construct peer support as entirely one thing or the other. And then fall into the trap of trying to say what peer support is and what it isn't anyway…

**Mark Hopfenbeck** is an anthropologist and assistant professor at the Norwegian University of Science and Technology, Norway where he is director for the longest running post-graduate program in Open Dialogue outside of Finland. He is also the training coordinator for the UK Peer-supported Open Dialogue Project together with psychiatrist Russell Razzaque and family therapist Val Jackson. Hopfenbeck is co-applicant together with Razzaque and a team of researchers led by Professor Stephen Pilling on a £2.1million grant application for the first large-scale randomised controlled trial on Open Dialogue involving six Trusts across the UK. Hopfenbeck administers a FB-group for Open Dialogue (https://www.facebook.com/groups/234079520082275/) and contributes to the POD Bulletin (http://www.podbulletin.com/). Hopfenbeck also teaches Norway's first post-graduate program in mindfulness.

## Peer-supported open dialogue: On Recovering Difference


**Abstract**

Peer-supported Open Dialogue (POD) is a further development of the Open Dialogue approach developed by Jaakko Seikkula and colleagues in Western Lapland during the past 30 years. Open Dialogue grew out of the Finish 'needs-adapted' psychosocial approach to psychosis as a community-based integrated treatment system that engages the person's social network from the very first meeting while incorporating the ideas and practice of dialogicity and reflecting processes with an emphasis on listening and responding in order to mobilize the resources of the person at the centre of concern and her/his network.

Peer-supported Open Dialogue aims to be a radically person-driven form of care. Essential to the model is the complete transparency of all discussions between the professionals being carried out with the person at the centre of concern present and preferably as part of network meetings. The approach gives full autonomy to the person at the centre of concern to decide when, where and with whom network meetings will take place. Persons with lived experience of emotional distress are actively involved at all levels of service development and delivery and peers from both within the NHS as part of the professional teams and from local community networks are encouraged to participate in the recovery process.

Central to the POD approach is an understanding of recovery which entails not only personal and social recovery, but also a collective cultural and political recovery based on a recognition of difference and diversity, pluralism and polyphony as an active resistance to hegemonic normativity. Individual biographical narratives are understood as historically and culturally situated within larger webs of relationships and power structures often including the burdens of poverty, discrimination and isolation.

If we are to create a sustainable model of care, the model itself must explicitly support participation in collaborative human rights activism with the potential to transform the personal to the political. Any democratically defensible idea of Recovery, in order to resist the constant forces of commercialization and co-option, must promote the critical values, skills and understandings needed to mobilize forces in our shared struggle against social, political and economic inequalities and their consequences for emotional distress.

**Mike Slade** is Professor of Mental Health Recovery and Social Inclusion at University of Nottingham and Chair of the European Network for Mental Health Service Evaluation (ENMESH). His main research interests are recovery-focused and outcome-focused mental health services, including Recovery Colleges, narratives and lived experience, citizenship, wellbeing, needs assessment and developing measures, e.g. INSPIRE, Camberwell Assessment of Need, Threshold Assessment Grid. He has written over 250 academic articles and published 11 books, including *Personal Recovery and Mental Illness* (2009), *Partnering for Recovery in Mental Health* (2014), *Wellbeing, Recovery and Mental Health* (2017) and *Positive Psychotherapy for Psychosis* (2017). His free booklets include *Making Recovery a Reality* (2008), *REFOCUS: Promoting recovery in community mental health services, 2nd edition* (2011), *100 Ways to Support Recovery* (2013) and *The empirical evidence about recovery* (2015), all downloadable at researchintorecovery.com.

## New frontiers in recovery research

**Abstract**

Many recovery-related initiatives are now widely accepted, including Recovery Colleges, peer support work, Individual Placement and Support, co-production, strengths-based and coaching approaches. They have randomised controlled trial evidence, national and international policy support, and are moving towards widespread implementation. In this talk the current scientific, policy and implementation evidence will be reviewed, and new frontiers will be identified. The next stages in developing systems which fully support recovery will include increased cross-fertilisation between recovery and wellbeing, more sophisticated approaches to supporting the development of an identity as a 'person in recovery', understanding the relationship between recovery and other aspects of human experience such as social connectedness and spirituality, and harnessing digital technologies to increase the visibility of recovery narratives. Current research in many of these areas will be described.

**Jayasree Kalathil** is an independent researcher, writer and mental health activist. Her work focuses on linking activism and mobilising user/survivor participation from marginalised and minoritised groups to influence knowledge production, policy and practice on issues of racialisation, gender and human rights in mental health. Her publications include a study of black women's narratives, *Recovery and resilience* (2011) and the co-authored book *Values and ethics in mental health* (2015). A special issue of *Philosophy, Psychiatry & Psychology* on mental health user/survivor research, co-edited with Nev Jones, is forthcoming in 2016. She has also published a children's book *The Sackclothman* (2009) and is currently working on a translated anthology of short stories from her mother tongue Malayalam into English, a project funded by the Thunchath Ezhuthachan Malayalam University, Kerala.

**The narrative of a 'race person': Reflecting on 10 years as a researcher navigating the 'recovery' discourse**

**Abstract**

Fourteen years ago, I moved to England from India and an important thing happened to my identity: I became a 'BME' person. As one of a handful of survivor researchers from racialised minority backgrounds with an interest in the intersections of 'being mad' with other social identities and related systems of oppression, this new identity marked me as eligible for entry into forums of knowledge production in which I was soon performing the task that Sara Ahmed has termed "embodying diversity by providing an institution of whiteness with colour" (*On being Included: Racism and Diversity in Institutional Life*, 2012). Precisely ten years ago, after resigning from a project studying 'race equality in mental health' housed in a white organisation influential in shaping one of the key recovery programmes in England, I set out as a freelancer. One of the first tasks I was asked to do was to get involved in a 'think tank' exercise on recovery organised by another white organisation (*Life and Times of a Supermodel: The Recovery Paradigm for Mental Health*, 2008). Since then, I have been, sometimes frontally and sometimes marginally, involved in the discourse on recovery, including the only study in England to explore Black and Asian women's views on madness and recovery (*Recovery and Resilience*, 2011).

My presentation will look back at this engagement along three lines: 1) the proliferation of studies and models of recovery since the mid-to-late 2000s and their implications for policy and practice; 2) the critique of the neo-liberal re-articulation of recovery and the call to 'reclaim' our narratives; and 3) the rejection of the idea of recovery – and recovery narratives – as a radical political stance. In all three, I will trace the processes of racialisation that, on the one hand, preserve and perpetuate white privilege as a structural, spacial and embodied form of racism and, on the other, invalidate or marginalise the experiences of and knowledge produced by people from minority ethnic communities.

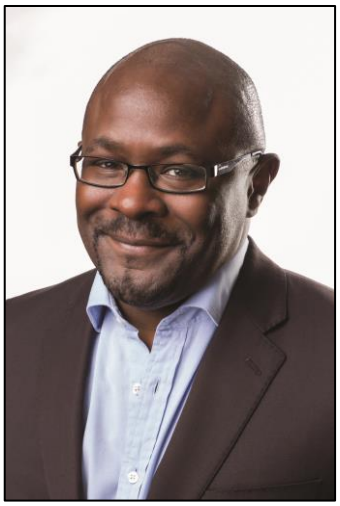
The presentation will self-consciously adopt a 'personal narrative'/story telling mode as befitting the primary mode of participation expected of service users in the recovery debate.

**Isabella Goldie** has 34 years' experience in mental health including 10 years as a registered mental health nurse. Her time working in the voluntary sector has including setting up and managing a range of community mental health programmes including 6 years as a Clubhouse Director where she held a role in supporting the international clubhouse development as a faculty member working in NYC. She joined the Mental Health Foundation in 2004 as Head of Scotland and is now Director of Development and Delivery for the UK. Within her time leading MHF in Scotland Isabella supported the development of VoX the national collective advocacy programme and developed the Amaan programme to support woman refugees and asylum seekers. She has a master in public health and is one of the two lead managing partners in the See Me anti stigma campaign in Scotland. Isabella now leads a wide a range of UK and international mental health

## Surviving or Thriving? Creating a Movement for Change

**Abstract**

In The Mental Health Foundation's Mental Health Awareness Week survey of over 2,200 people across the UK we found that 65% of the population stated that they had experienced a mental health problem in their life time. This figure rose to almost 3 in 4 young people aged 18-34. Of concern was that when asked how many people were experiencing a high level of positive mental health only 13% agreed that they were. It seems that mental health is eroding across society with more people than ever before feeling that they are merely getting by. Alongside this mental health problems are on the increase with some groups doing worse than others, including lone parents, young women and those that are unemployed. Mental Health Problems are set to become the public health challenge of our time. Services are struggling to offer adequate support and too many people are experiencing an unacceptable burden of distress with lives being lost. If we are to turn this alarming trend around we need to view mental health differently, understanding that it is a universal asset that we all need to have a stake in protecting. Although there is a need for specialist support at times in people's lives much of mental health is determined in family homes, neighbourhoods, schools, workplaces and through those social protection systems that are all too often failing us. A cultural change is needed – one that involves all of us, to ensure that children are getting the most nurturing start in life, that people are able to live in inclusive and cohesive communities and that it is possible to seek help early without fear of judgement or repercussions.



**Kwame McKenzie** is CEO of the Wellesley Institute. He is an international expert on the social causes of illness, suicide and the development of effective, equitable health systems.
As a physician, researcher and policy advisor, Dr. McKenzie has worked to identify the causes of illness and in cross-cultural health for over two decades. He is an active, funded researcher of social, community, clinical and policy issues with nearly 200 academic publications including five books.

In addition to his post at Wellesley Institute, Dr. McKenzie is the Director of Clinical Health Equity at CAMH. He is a full Professor and the Co-Director of the Division of Equity Gender and Population in the Department of Psychiatry, University of Toronto.

Dr. McKenzie sits on the Boards of the United Way Toronto and the Ontario Hospitals Association. He is a Senior Fellow at Massey College.

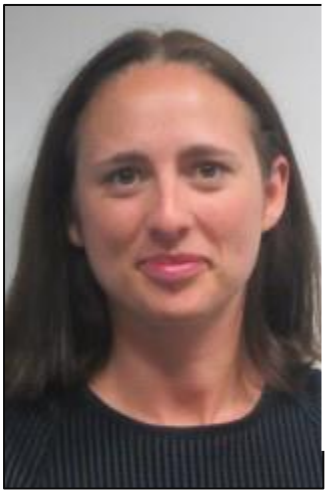
Dr. McKenzie is a member of the Ontario Government's Mental Health and Addictions Leadership Advisory Council and sat on the Expert Advisory Group for Ontario's Homelessness Strategy along side numerous other committees. He has a respected track record for setting up award winning services, training clinicians and researchers, offering clinical care to some of the most marginalized patients, and helping to develop health policy for Governments in Canada, Africa, Europe, the Caribbean and United States.

Dr. McKenzie completed his medical training at the University of Southampton and was trained in psychiatry at the Maudsley Hospital and Institute of Psychiatry and Harvard University.

## Building societies that promote recovery

**Abstract**
60% of the risk of developing mental health problems and the ability to move towards recovery are linked to the social determinants of health. Governments and service providers speak about action on these areas and about building community and individual resilience but often do little. This is partly because they need specific concrete initiatives that have a clear cost benefit before they move forwards. They need us to move from the theoretical towards practical impact.

This talk will discuss what we know from the literature works to decrease risk of developing mental health problems and what sorts of community interventions promote societies where recovery is more likely. It will highlight specific interventions from Canada and beyond across different ethnic populations that have proved effective. It will also discuss the emerging findings of the impact of basic income on mental health.

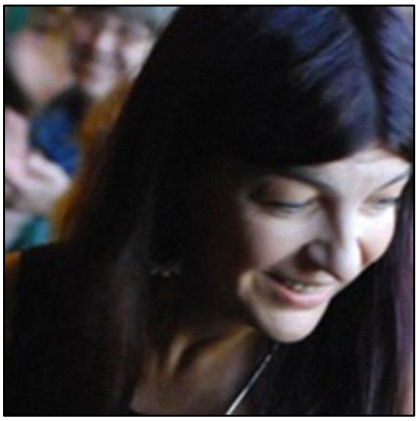


**Nicola Kay** is a Deputy Director leading for NHS England on Personalising Care policy and strategy. In this role, Nicola leads on the development of policy across the personalising care agenda and expansion of the model to new areas. She develops and leads the approach to scaling up and mainstreaming personalised care, including embedding IT infrastructure and maximising the opportunities from skills development, legislation and stakeholder engagement. Prior to joining NHS England in 2016, Nicola worked for 10 years as a Civil Servant in a range of central government policy, strategy and finance roles, including leading on health and social care spending at HM Treasury and leading HMRC's strategy function.

## A personalised approach to mental health: how to get person-centred, integrated and better value services


### Abstract

NHS England are working with partners across the NHS, local government and the voluntary and community sector to deliver a comprehensive, whole population approach to personalised care. This session will explore how this personalised approach is being applied to mental health services and how it can help to deliver more person-centred, integrated and better value for money services.

**Jasna Russo** is based in Berlin, Germany where she works as an independent researcher. She is a long-term activist in the international user/survivor movement. Jasna has an MA in clinical psychology and has worked on both survivor-controlled and collaborative research projects, including several large-scale international studies. Her articles have been published in anthologies and journals in Germany and the UK. Together with Angela Sweeney, Jasna is the editor of "Searching for a Rose Garden. Challenging Psychiatry, Fostering Mad Studies" published by PCCS Books.

## Connecting first-person knowledges of madness and distress: From individual stories to a collective and inclusive epistemology


### Abstract

Personal accounts of madness and distress have been gaining more recognition in recent years and they are increasingly being used in mental health and psychiatric research in the western world. Nevertheless, the inclusion of these sources in official knowledge production remains an optional adjunct, often meant to extend and enrich clinical expertise with 'subjective' perspectives. Such approaches consider our multiple experiences as individual units that are almost entirely disconnected and de-politicised. Moreover, although the accumulation of this evidence may interfere with the dominant discourse, it is still largely being performed by 'objective' specialists. Relying on a distinction between first- and third-person perspectives rather than the one between 'subjective' and 'objective' knowledge, I will discuss the limitations of such approaches and the way that they ultimately preserve the biomedical paradigm of madness and distress. My special interest is in the potential development of first-person plural understandings and the prospects for generating and advancing the collective knowledge of people deemed mad or mentally ill. I explore the many challenges of such a project while also arguing for its deep value and urgent necessity.

**Manoj Kumar** is the Clinical Director of The Mental Health Action Trust (MHAT), India which provides comprehensive psychosocial care in resource-scarce settings through community health work volunteers. MHAT provides long term care for more than 4000 economically backward patients in the community through more than 50 centres in Kerala, India.

Dr Manoj Kumar worked in Leeds till returning to India in 2008. He was awarded the "Volunteer Psychiatrist of the Year 2014" award by the Royal College of Psychiatrists and the Fellowship of the Royal College of Psychiatrists (FRCPsych) in 2015. He has been selected as an Ashoka Fellow in 2017.

## The feasibility of mental healthcare delivery by volunteers in a co-production model of mental health care delivery in resource-scarce settings

**Abstract**

The search for new models of mental health care delivery becomes desperate when one fully understands the enormity of the problem and the huge deficits in the availability of mental health care resources, both human and material, in resource-scarce countries. In our model, which has evolved organically over the last 9 years, involvement of non-professional health workers, mostly volunteers takes centre stage. From being supportive players, they graduate to become actual providers of skilled psychosocial care. For this to happen, there should be systems of training, retraining, support and round the clock availability of emergency supervision besides high levels of self-motivation.

# DEBATE SPEAKERS

**Graham Meadows** is Professor of Adult Psychiatry in the Department of Psychiatry at Monash University where he directs 'Southern Synergy', a joint University and Health Service Research Centre. Graham is a prominent figure in innovation in mental health care in Australia, with national and international profiles in areas including: GP shared care; equity in resource distribution and applications of mindfulness in clinical mental health practice. He has headed large-scale studies investigating mindfulness and recovery oriented practice as clinical and service level interventions and leads the editorial team on a major textbook of multidisciplinary mental health care practice.

**Vrinda Edan** has worked in the consumer movement for 19 years, and for 10 years led and grew the lived experience workforce at Monash Health. Currently working on PULSAR, she also works with St Vincent's Hospital Melbourne as Consumer Workforce Development Officer, State-wide Learning and Development, exploring the needs of the Lived experience workforce.

Vrinda uses a Human Rights framework, supporting consumers to regain choice and control in their lives and is currently Chair of the Board of the Victorian Mental Illness Awareness council (VMIAC).

Using principles of peer work, mutuality and empowerment, Vrinda's work with consumers, their families and carers, and organisations supports services to respond to the needs of the community, improving the experiences of consumers, their

**Stynke Castelein** is professor of recovery from severe mental illness at the University of Groningen, Faculty of Behavioural and Social Sciences and head of the research department at Lentis Psychiatric Institute, Groningen, The Netherlands.

Her research focuses on recovery of symptoms, community functioning, and personal identity. She is currently involved in research projects concerning: self management, therapeutic alliance, stigma, peer support and skills training, peer support work, resource groups, routine outcome monitoring, and recovery outcome measures (12 PhD students).

She is member of the World Association of Social Psychiatry, Section on Recovery. In addition, she was co-author of the multidisciplinary guideline for schizophrenia (2005 and 2012) and the quality standard on psychosis and schizophrenia (2017) in the Netherlands.

**Karen Machin** works freelance in mental health from a perspective of lived experience as both a service user and a carer. She is a member of the peer training team at the Institute of Mental Health which offers a range of provision to support peer working, including accredited modules. Her current research interests include the impact of technology on peer support.

**Glenn Roberts**
Prior to a creative step into active retirement, Glenn worked in rehabilitation and other branches of adult psychiatry, in Bristol and Devon, for 35 years. He has previously been academic secretary of the Faculty of Rehabilitation and Social Psychiatry at the RCPsych and the RCPsych lead on Recovery. He was a consultant with what became the ImROC program (2007-2015), continues as adviser to Recovery Devon and has a growing interest in Buddhist philosophy, mindfulness and meditation.

**Parallel Session 1**
**Monday 18 September**
**3.30pm-5pm**

**Parallel Session 1.1**
**Theme: Re-situating recovery**
**Room: LT2**

**Julie Gosling**
**Lived experience is more than service user porn! - Creation of an online resource for mental Health nurse students**

***Introduction***
Concerns around the consumerisation of survivor narratives have been catalogued as 'survivor porn' – suggesting a vicarious thrill without genuine engagement or commitment to learn from the telling of mental distress journeys. Commodification of survivor stories as 'hard-sell recovery products' has further brought lived experience into disrepute. The peer-led co-production of an on-line learning resource for nurse-students rescues narrative as an invaluable tool for practitioner reflection, particularly where it is navigated by a set of peer-produced questions and learning points.

***Methodology***
A survivor and academic research duo secured funding to co-produce a set of digital clips featuring personal experience of care within mental health settings. Project steering comprised two peer co-workers, two nurse students, an academic on-line learning expert and the research leaders. The peer researcher and workers consulted widely among mental health communities to identify benchmarks of valued support which were used as the focus for a filmed group sharing of lived experiences of nine survivors in a warts and all discussion around acceptable practice standards in care and support. Clips were edited by the peer team and then piloted by the nurse students across learning cohorts. Critical areas for reflection were identified through peer focus group and through the nurse pilot. Navigation is presently being developed by the peer researcher, with a view to launch on protected website later this year, supported with co-authored publications and wider dissemination.

***Results***
All partners found the processes of co-design and co-production emancipatory. Film footage released 90 usable clips with minimal editing. Peer speakers were validated and saw their voices portrayed accurately and powerfully. Nurse audiences reported feeling challenged motivated and inspired by what they heard and were excited to be involved in shaping the learning further.

***Discussion***
An empowering and dialogical framework enables mutual creativity and a levelling of power throughout production and piloting where every voice is heard and valued. Co-production as process involves a reshifting of values and attitudes on all sides. We discuss how to move the 'telling and hearing' of survivor narrative from cosy to collaborative in educating future practitioners and resituating recovery within the heart of lived experience.

**Steve Gillard**
**Co-production, lived experience and large multidisciplinary teams: Making it meaningful in practice**

***Background***
Involving people with lived experience in a meaningful way in research is something many researchers struggle with. Difficulties range from lack of funding and time, to anxieties about sharing control of the project, which can affect both service users consulted and those working in a dual academic and 'expert by experience' role. Those in a dual role can draw on two sets of knowledge in their work. This process can be either supported or suppressed by the working environment. This talk presents our experiences working in a large multidisciplinary research team largely comprised of those with the dual role of service user researcher and academic.

***Methods***
We use reflective practice, group and one-to-one discussion to explore the research practices and processes we use. We create a 'safe place' in which lived experience can be shared and used to influence the way we work.
***Results***
We design and conduct research in a way which has a much stronger service user voice, and embraces the heterogeneity of service user perspectives. We describe how, at times, we can 'look through the psychiatric lens' with service users participants, using shared 'knowing' about the constructs of psychiatry.
***Implications***
Service user voices and perspectives can be central to all phases of research projects, making co-production meaningful.

**Roberta Casadio**
**Developing a Whole Life Recovery Community and Recovery House in Trieste, Italy**

***Introduction***
The Whole Life Recovery Community offers opportunities for individual service users, their family members and co-workers to commit to work together in new ways to examine their life stories and the importance of embarking on a recovery journey. The Community has been established in 2015 by Trieste Mental Health Department, Italy with the International Mental Health Collaborating Network, local Cooperatives and Associations, Peer Support Workers and Volunteers. Individual service users and their families who became part of the community were already receiving long term support and treatment from the Trieste Mental Health Services: many of them hear voices and experience other unusual states. The length of a person's stay is flexible, however a minimum of six months is recommended as best practice.
***Methods***
For people to embark on a recovery journey, time and space is essential, for this reason the community includes a Recovery House, a place where this can be achieved and where people are assisted to develop and pursue their recovery journey. The key principle is that everybody involved is an equal and full partner in the process of development and implementation. Our work together is founded on the principle of "Nothing About Us Without Us" and this value has led to a critical examination and change to our work practices, protocols, assessment, treatments and diagnoses. A fundamentally important part of the community was to ensure that family members and social networks were fully involved in the programme from the beginning. To ensure continuity of learning and support individual service users and their families are encouraged to stay part of the community following their stay in the recovery house.
***Results***
Results have been very encouraging, to date (March 2017) 24 service users and their families have become part of the recovery community. We have seen substantial improvements in people's personal development and resilience, not only the core service user group but also their families and friends.
***Discussion***
We would like to share our learning about utilising community development values in mental health recovery; how we engaged families and social networks and co-workers in finding new ways to work as partners. We would like to ask the question "How do we shift the culture of a mental health service away from a clinical mind-set toward a whole life perspective".

**Kristin Ørjasæter**
**I've got a life. Negotiating meaning in participatory arts**

***Introduction***
People who strive with mental health problems over an extended period, may also struggle finding meaning in life.

***Method***
This hermeneutical phenomenological study explores how engaging in participatory arts negotiate meaning for people with long-term mental health problems. Data were collected by in-depth interviews with 11 participants in a music and theatre workshop located in a mental health hospital in Norway. The interviews were analysed using thematic analysis.
***Findings***
Preliminary findings reveal two central themes: a) A reference point in a person`s existence and b) Bringing life back.
***Results***
The findings indicate that engaging in participatory arts, provides meaning both in the moment and general in the participants lives. When the participants experienced a sense of meaning, they felt less need of treatment, increased orientation to the society and belief of recovery.

**Simone Arbour**
**The implementation and impact of a recovery college at a tertiary mental health hospital in Canada**

***Introduction***
The purpose of this presentation is to outline the implementation and impact of a recovery college within a tertiary mental health care hospital in Canada. While recovery colleges are common in the United States, United Kingdom and Australia, they are new to Canada. This presentation will also highlight the difficulties in implemented recovery-related initiatives into the Canadian Healthcare context, given the constraints associated with the existing risk-averse mental healthcare landscape. We will discuss some of the ways we overcame these barriers in order to adhere to the fidelity of an authentic recovery college framework.
***Method and Results***
The recovery college development at Ontario Shores Centre for Mental Health Sciences was modelled after other successfully launched colleges in England and Australia and attempted to adhere to the recovery principle that courses be co-designed and co-facilitated with those whom had lived experience with mental illness. Peer support was also offered to help students identify learning goals and enrol in courses that supported those goals. Twenty-one courses were incorporated into the first semester launch of the college. The college was offered to both inpatients and outpatients receiving treatment at the hospital. Each student completed a Personal Recovery Outcome Measure and Individualized Learning Plan to serve as the basis of forming their recovery learning goals. Students' learning goals and content knowledge were tracked both pre- and post- participation in the college. Qualitative data about their experience in the recovery college was also collected. Evaluation data for the first two semesters as well as the vision for the college will be discussed.

**Parallel Session 1.2**
**Theme: Recovery for different groups**
**Room: LT5**

**Agnes Higgins**
**Supporting recovery through co-facilitated programmes: The EOLAS Programmes**

***Introduction***
Psychoeducation interventions can be powerful mechanisms through which positive psychosocial outcomes can be achieved. To date, such programmes have predominantly been developed and led by clinicians with minimal input from service users or their families. Underpinned by the recovery principle of genuine partnership between service users, family members, clinicians and academics, the EOLAS programme is a co-produced, co-delivered and co-managed information programme. Its content focuses on recovery from mental health difficulties and is designed for service users with a diagnosis of schizophrenia or bipolar disorders and their family members.

***Methods***
To evaluate people's experiences of participating and facilitating the EOLAS programmes as well as the impact on outcomes a sequential mixed method design was used. Family members, service users and facilitators were involved in the completed pre- and post-programme questionnaires. In addition an integrated qualitative component comprised of semi-structured interviews conducted with people from all three groups after programme completion.
***Results***
Analysis of data from the pre-and post-programme questionnaire revealed statistically significant changes in knowledge, attitudes and skills. In the interviews, participants reported increases in knowledge, confidence and sense of empowerment and appraised the opportunity to meet people in similar circumstances, share their experiences, learn from each other and provide mutual support as particularly valuable. The dual nature of the programmes' co-facilitation was also viewed positively by both the facilitators and the majority of participants. While some people may have concerns about the feasibility of training clinician and peer facilitators together, in the belief that the knowledge and skill difference is too great, this study supports both the feasibility and acceptability of this approach.
***Discussion***
The study's findings suggest that the EOLAS programmes induce positive psychosocial benefits and offer meaningful opportunities for participants to learn and contribute in a genuinely collaborative and respectful environment. Larger replication studies are required in the future to confirm study findings and examine long-term outcomes.

**Rebecca Murphy**
**Restoring meaning to asylum seekers' lives in Ireland; The key to their mental health recovery?**

***Introduction***
Due to a myriad of pre and post migratory factors, asylum seekers are believed to be highly susceptible to developing mental health difficulties. Many host countries' attempts to alleviate such distress are rooted in biomedical understandings of mental health difficulties and treatment. However, many asylum seekers hold socio-cultural and/or spiritual explanatory models for mental health and mental distress and so strongly desire preventative and responsive strategies which align with this belief system.
***Methods***
Framed within a qualitative methodology, purposive sampling of asylum seekers from African countries who had experience of mental health difficulties and accessed mental health services in Ireland resulted in the conduct of 16 semi-structured one to one interviews. A holistic analysis framework of narrative form and content was utilised to analyse data.
***Results***
Participants appraised that the post-migratory conditions in Ireland suffocated the various sources from which we, as human beings, derive meaning in life including self-efficacy, purpose, belonging, and love. From participants' perspective, living a life devoid of meaning had contributed to the onset and/or exacerbation of their mental distress and had severely compromised their capacity to recover from pre-migratory experiences of torture and/or trauma. The medicalised response of mental health services to their distress was deemed by the majority of participants to be inappropriate. They spoke of their desire for socio-ecological strategies which would harness their resiliency, nurture their self-worth, self-value, and hope and consequently assist to restore meaning in their life. A facilitation of peer support, community integration initiatives, and educational endeavours were appraised by participants to be potentially effective interventions in this regard.
***Discussion***
Study findings highlight that host countries current and future response to asylum seekers' mental distress must be socio-ecological in orientation and strongly align with their explanatory models for mental health and mental health difficulties.

**Frank Keating**

**Socially oriented approaches to recovery for African and Caribbean men: some preliminary findings**

***Introduction***

African and Caribbean men are over-represented in mental health treatment and care, despite various initiatives to find solutions for this situation, the concerns for this group persist in reports over the last 10 years.

This presentation will discuss preliminary findings from a project that aims to identify the range of socially focused services offered to help African and Caribbean men with mental health problems towards achieving recovery, and to gain information about these men's experiences of and responses to these services. Socially oriented approaches are those that aim to support people to build and maintain a meaningful and satisfying life and personal identity.

***Methods***

The study utilises a qualitative participatory design to conduct in-depth interviews with triads of service users, a nominated carer/supporter and service provider/practitioner to explore their views about recovery, what, in their experience, supports recovery for African and Caribbean men, and how services across all sectors can be developed to support these men better. An Interpretive Phenomenological Approach is used to analyse data.

***Results***

Emergent themes from preliminary analysis indicate divergent perspectives on what recovery means for African and Caribbean men. Challenges are identified by participants around (de)-personalising experiences of services; lack of support and understanding; loss of independence/control; gender norms (masculinities). Recovery is a complex journey. Valued enabling aspects include: safe spaces/environments; sensitivity to cultural/racial and gendered (masculine) identities; activities and peer support building resilience and empowerment.

***Discussion***

Recovery is a nuanced process and in the context of racialisation it is vital to take this into account in attempts to provide services that will support African and Caribbean men towards the independence which they demand and need.

**David Rosenberg**

**The effects of peer support workers on psychiatric environments – Recovery orientation as outcome**

***Introduction***

While an increasing number of studies point to the positive effects of peer support workers in mental health services, there is a continuing call for research that targets individual outcomes which can be measured and provide evidence for the effectiveness of this method. Individually oriented outcomes tied to specific interventions, such as those called for in the Swedish national guidelines for mental health services, may not however capture the broader effects of hiring individuals with lived experience in traditional psychiatric services.

***Method***

An interview study of users who had contact with peer support workers in five Swedish psychiatric outpatient services was completed as part of a broader study that also targeted staff and program managers. This study occurred at the same time that the new national guidelines in Sweden were being developed, based on an international review of evidence, with peer support being considered as an intervention.

***Results***

While the interviewed users confirmed many of the outcomes that had been reviewed in the international literature regarding hopefulness, strategies for recovery, trust and mutuality, they also described their perception of the environmental implications of employing these workers. They describe the peer support workers as mediating the distance between patient and staff, as creating a more equal standing on the units, and as

confirming that the professionals believe in recovery and can therefore be trusted.

***Discussion***

These findings suggest that the outcomes of peer support are not solely individual and significantly contribute to the development of recovery-oriented services with wide-ranging benefits. These results will be discussed in relation to the development of the national guidelines and other evidence-based recommendations, which are challenged by innovations which influence the social context of care.

**Leora Pinhas**

**Recovery High School: adapting recovery model for an adolescent inpatient unit**

***Introduction***

Literature on recovery-oriented approaches in adolescent inpatient programs or the treatment of eating disorders (ED) is scant. The Eating Disorder Residential Program (EDRP) was explicitly created in 2014 to provide an alternative for adolescents who had multiple mental health co-morbidities and were treated unsuccessfully by existing settings. After functioning more traditionally in its first year, a developmentally appropriate recovery model: Recovery High School was integrated into the EDRP in the second year. This resulted in a well-received, diagnosis-agnostic treatment that incorporated concepts of transparency, patient and family directed care and co-design present in adult mental health discourse, but relatively rare in adolescent mental health and ED literature.

***Methods***

Data was collected over the two year period. Quantitative data was collected using a questionnaire battery administered at admission and discharge, including demographics, diagnoses, ED behaviours (EDE-q), depressive symptoms (CDI2), anxiety symptoms (MASC2), heights and weights. Population level data collected included use of restraints and average length of stay (LOS). Data from year 1 was compared to year 2. Descriptive analyses, chi-square analyses, t-tests and ANOVAs were performed in analysing the data.

***Results***

Twenty seven adolescents (Female=25; Male=2), with a mean age of 16 years (SD=1.14) were included in the sample. Patients had a minimum of two prior inpatient admissions and the most common diagnosis was anorexia nervosa (91%). Concurrent diagnoses were present in 68% of the sample, most commonly anxiety disorders (41%). The EDE-q was significantly improved from admission (M=3.55; SD=1.73) to discharge (M=1.41; SD=1.30) ($p<0.001$). A similar pattern was found on the MASC2 ($p<0.05$) and the CDI2 ($p<0.01$). The LOS and use of restraints were significantly reduced in year 2 with Recovery High School.

***Discussion***

The results of this pilot study suggest that adolescents with chronic and/or complex EDs can benefit from a recovery-focused inpatient treatment model.

**Parallel Session 1.3**
**Theme: Recovery for different groups**
**Room: LT4**

**Joeri Vandewalle**

**"Constructing a positive identity": A qualitative study of the driving forces of peer workers in mental health care systems**

***Introduction***

There is growing recognition in mental health of the value of the perspective of individuals with lived experience of mental health problems and mental health service use. As peer workers, these individuals can use their specific experience to benefit and support peers and professional caregivers, and to participate at all levels of mental health care systems. This study aimed to develop a conceptual framework representing the driving forces of peer workers in fulfilling their position in mental health care systems.

***Methods***
A qualitative interview approach was employed using principles of grounded theory. Over a period of 5 months, semi-structured interviews were conducted with 14 peer workers in residential and community mental health care systems.
***Results***
The conceptual framework that emerged reveals that peer workers strive to construct a positive identity. This process is powered by driving forces that reflect a desire for normalization and an urge for self-preservation. Peer workers realize a meaningful employment by using their lived experience perspective as an asset, liberating themselves out of restrictive role patterns, and by breaking down stigma and taboo. As a precondition to engage in these normalization processes, peer workers perceive they need to secure their self-preservation by balancing the emergence of adverse emotional fluctuations.
***Discussion***
The conceptual framework can inform the development of work contexts in which peer workers have an authentic and meaningful contribution while being offered sufficient support and learning opportunities to manage their wellbeing.

**Bart Debyser**
**The transitional process from mental health patient to mental health peer worker: exploring the underlying dynamics**

***Introduction***
There is a growing body of research that broadens our view on how peer workers experience their integration in mental health care systems. Nonetheless the transition from patient to peer worker is not fully understood. The aim of this study was to gain an in depth understanding of this transitional process from the stance of non-trained peer workers.
***Methods***
A qualitative study-design based on a grounded theory approach was set up. In depth interviews were conducted with 18 non-trained peer workers throughout Flanders.
***Results***
The findings reveal how peer workers face challenging and opposing dynamics within and outside themselves that both threaten and safeguard their need for self-preservation. Becoming a peer worker and using one's own lived experience offer exciting opportunities to enhance the personal recovery process and ability to stop or slow down the detrimental consequences related to mental illness. Becoming a peer worker also involves uncertainty and demands weighing and comparing risks, benefits and personal readiness in terms of the experienced competencies required of peer workers. Alongside the dynamics within the peer worker, external factors such as how the peer worker experiences trust, equality and transparency can affect positively or negatively the transitional process of becoming a peer worker. Based on these findings, a dynamic model that illustrates the interplay between these different internal and external dynamics was developed.
***Discussion***
The findings were helpful in understanding the process of personal growth that is needed to become a peer worker. The study clarified the flexible conditions that have to be put in place and stressed the importance of sustained and ongoing attention to the need for self-preservation, not only in the interest of peer workers themselves but also to ensure that peer workers can exert their authentically unique role in the mental health care system.

**Joeri Vandewalle**
**Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review**

***Introduction***
Peer workers perceive and experience personal, interpersonal and contextual barriers to their integration in mental health services. An integrative multi-level
approach is needed to address these barriers and to establish an authentic integration of peer workers. A literature review was designed to answer the following question: What are

peer workers' perceptions and experiences of barriers to the implementation of peer worker roles in mental health services?

***Methods***

A review of qualitative and quantitative studies was conducted. A comprehensive electronic database search was undertaken between October 2014 and December 2015 in PubMed, CINAHL, Web of Science, The Cochrane Library, and PsycARTICLES. Additional articles were identified through handsearch.

All articles were assessed on quality. A thematic analysis informed by a multi-level approach was adopted to identify and discuss the main themes in the individual studies. Reporting was in line with the 'Enhancing transparency in reporting the synthesis of qualitative research' statement.

***Results***

Eighteen articles met the inclusion criteria. All studies adopted qualitative research methods, and three used additional quantitative methods. Peer workers' perceptions and experiences cover a range of themes including the lack of

credibility of peer worker roles, professionals' negative attitudes, tensions with service users, struggles with identity construction, cultural impediments, poor organizational arrangements, and inadequate overarching social and mental health policies.

***Discussion***

This review can inform policy, practice and research from the unique perspective of peer workers. Mental health professionals and peer workers should enter into an alliance to address barriers to the integration of peer workers and to enhance quality of service delivery. Longitudinal research is needed to determine how to address barriers to the implementation of peer worker roles.

**Bart Debyser**

**Mental health nurses and mental health peer workers: self-perceptions of roles and clinical competences**

***Introduction***

In a mental health care system that embraces a recovery oriented practice, the employment of mental health peer workers to work directly or indirectly with mental health care nurses is encouraged. To our knowledge, there is a lack of research that explores how nurses and peer workers perceive, and are satisfied with, their own roles and competences. The aim of this study was to clarify and understand these self-perceptions. This knowledge is needed if we want to integrate both distinct professions in a successful partnership.

***Methods***

A qualitative descriptive research design based on principles of critical incident methodology was used for this study. Twelve nurses and eight peer workers from different mental health care organizations participated in the research. A total of 132 reported cases were analyzed. Quality assurance of the results was achieved through multiple cycles of investigator triangulation.

***Results***

Two parallel patterns in both professional groups emerged by analyzing the data: both groups assign an important meaning to their team in determining their perspectives of professional competence and satisfaction.

Both groups critically reflect on their intervention in practice, mostly when they are not satisfied with their own (self-perceived) actions.

***Discussion***

The findings highlight the importance of paying more attention to identity construction, empowerment and role development of the mental health nurse and peer worker in their respective education and ongoing training, and how to maintain these roles and perspectives in team settings.

Further research is needed to gain a deeper understanding of factors that ameliorate or complicate the role development process of becoming a mental health nurse or a mental health peer worker over time.

**Bart Debyser**
**The formal training of mental health peer workers in Flanders: a practical example**

***Introduction***
Peer workers are an emerging workforce in the mental health system in Flanders. Formal training and education for peer workers in Belgium is still in its infancy. The position of peer worker has not yet been formally recognized and services struggle to clarify what the role is of a peer worker or ought to be. The aims of launching a 30 day pilot certificate program were: 1) to assist and coach a diverse group of applicant peer workers to acquire basic skills and competences to become a mental health peer worker; 2) to encourage traditional mental health care partners to acknowledge the (lived) experience of former service users.

***Methods***
In partnership with former service users and representatives of a wide network of mental health partners, a training program was developed and executed to support the personal development of the applicant peer workers. A steering group of representatives of the involved partners was established and authorised to monitor the application procedure, the individual learning process, program delivery and implementation of peer worker roles in the workforce.

***Results***
Twenty-five peer workers were trained successfully in the last two years. They expressed their appreciation for how the training was delivered. New opportunities for shared learning in a diversity of settings were created, and partners discovered the potential value of what peer workers can contribute to their organisations.

***Discussion***
The programme development was an inspiring journey for everyone involved. Overall the program significantly facilitated the integration of peer workers in traditional mental health care settings. In order to sustain the reached objectives, further attention should be paid to the ongoing training and support of the peer workers who became certified.

**Parallel Session 1.4**
**Theme: Prevention of mental ill-health**
**Room: LT1**

**Tom Vansteenkiste**
**PhotoVoice: Using the power of visual narratives to explore personal recovery in mental health**

***Introduction***
Images can facilitate and empower stories that contribute to recovery. This qualitative study, that took place in psychiatric services in Antwerp (Belgium), focuses on the significance of personal recovery in mental health. Through visual modalities like photography, the study explores what people suffering from mental illness perceive as important in their recovery journey. The objective is to provide possibilities to stay close to people's own experiences while at the same time giving them a voice.

***Methods***
The participatory method of PhotoVoice has been used, specifically to include the voices of these often unheard and marginalized group. Participants were given a camera to take photos of everyday realities and life experiences. A participatory analysis of the produced images was performed during group sessions with an emphasis on general themes and personal narratives. The recurring collection and analysis of images consisted of three stages: (1) selection of images by each participant, (2) contextualizing and storytelling about the images, and (3) codifying of themes or issues that arise from the images.

***Results***
The obtained images and stories reveal a visual presentation of four global categories that

empower personal recovery in mental health. They are distinguished as (1) a presence of significant others, (2) a connection to significant places, (3) performing of meaningful activities, and (4) importance of inner significance and existential aspects of life.

***Discussion***

The study demonstrates that the combination of photography and narratives is powerful towards the exploration of meaning in personal recovery. The directness and accessibility of a photo offers a framework that enhances other ways of communication, which is especially beneficial with people lacking verbal fluency. Images facilitate storytelling and make recovery more tangible. The participatory approach of PhotoVoice, resulting in a photo exposition, advances empowerment and fosters an interaction with oneself, the group and the surrounding environment.

**Mary Birken**

**Assessment of a framework focusing on time-use, activity and participation to promote mental health and well-being**

***Introduction***

Current approaches to promoting mental health or preventing mental ill-health focus on specific diagnosis, or use educational, psychological approaches or coping strategies. Yet how people allocate time into patterns of daily activities can also impact on people's mental health and well-being. This suggests a broader focus is needed to promote mental health. The "Do-Live-Well" evidence-based framework expresses promotion of health and well-being in terms of time-use, activity patterns and participation. An outline of the framework will be presented.

***Methods***

To assess the utility of the framework and its contribution to mental health promotion, two studies were carried out. A systematic review of interventions that use time-use, activity patterns and participation to promote health was carried out to identify if current interventions reflect the Do-Live-Well framework. Additionally, a rapid review of models, frameworks and theories of well-being and health was carried out to locate the framework within existing theory.

***Results***

No current interventions were found that reflected all the components of the framework. Existing models, frameworks and theories do not cover the breadth of components within the Do-Live-Well framework nor focus on use of activity.

***Discussion***

The framework is unique in its focus on dimensions of experience and key activity patterns that promote health and well-being. The framework has the potential to be used at an individual or community level to support the development of intervention that support meaningful connections within communities and meaningful roles within that to enhance well-being and mental health.

**Catherine Winsper and Anne Crawford Docherty**

**Understanding mechanisms of change underpinning interventions for sustainable recovery in mental illness: A realist logic model systematic review**

***Introduction***

An understanding of recovery as personal and subjective has developed internationally within mental health systems, and now underpins mental health policy in many countries. Nevertheless, there is a need to further develop recovery-oriented services, which emphasise collaborative working with consumers, families, and their communities. This paradigm shift is conceptualised as "new" or "sustainable" recovery. In the current review, we adopt a systematic logic model approach to shed light on how, and in which contexts, interventions for sustainable recovery may work.

***Methods***

A combination of rigorous and transparent review methods (i.e., systematic searching,

identification, selection, and extraction of papers) with a theory driven logic model synthesis of the data. We reviewed the extant literature to develop a tentative logic model of how interventions may bring about sustainable recovery in mental health. The model was developed iteratively in collaboration with four NHS Trusts in the West Midlands as part of the MERIT Vanguard programme. The tentative logic model will provide the framework for our systematic review of the literature.

***Results***

Our logic model outlines interventions, mechanisms, recovery processes and outcomes. Interventions are grouped into the typologies of education, social prescription, and consumer-led. Short-term outcomes of interventions include: increasing choice and control; providing upward social comparisons; increasing awareness, exposure, and skills; encouraging dialogue; facilitating co-construction and participation; developing community networks; and flattening hierarchies. These, in turn, are proposed to lead to three key recovery mechanisms: hope & self-determination, stigma reduction, and recovery capital. Contextual moderators include: illness stage, cultures within mental health services, funder attitudes and resources, sex, and ethnicity.

***Discussion***

Logic model methodology presents an ideal tool for conducting a systematic review to go beyond just determining which interventions for recovery work, by advancing our understanding of how and in which contexts these interventions may work.

**Noushig Nahabedian**
**Coaching conversations for recovery**

***Introduction***

Slam Partners and SLaM Recovery College have worked collaboratively over the past three years to co-deliver a co-produced programme for service users, carers and healthcare professionals wanting to develop and understand how coaching conversations can enable people to be more active in their recovery. Coaching is fundamentally about seeing an individual as “the expert in his or her life…as creative, resourceful and whole” (ICF, 2017) and empowering an individual to “achieve self-determined goals related to health and wellness” (NCCHWC, 2016).

***Method***

The two-day experiential programme is based on the REACH© framework of coaching (Slam Partners). Once completed, participants are then eligible to attend a Masterclass where they can practice and refine their skills. Evaluation forms were completed by attendees of the two-day programme as well as by attendees to the Masterclass. The evaluation form comprised of a mix of open and closed ended questions. A thematic analysis was conducted on the responses.

***Results***

36 evaluation forms were analysed: 22 identified themselves as service users; 9 as staff; 5 as supporters/ carers. All but two respondents stated that they felt more hopeful as a result of taking part in the course. The responses were themed and indicated that as a result of attending the programme individuals felt:

1. More able to have difficult conversations
2. More confident
3. That coaching could help them in their personal and professional lives
4. That coaching could help them self-coach to achieve goals and ‘get where they want’
5. They could be more caring and compassionate to themselves.

***Discussion***

The responses provide a sound basis to further develop coaching conversations as a skill to support recovery focussed care. To promote self-determined goals and recognise the resourcefulness of each individual it would be beneficial to continue the programmes and further the coaching approach.

**Stephanie de la Haye**

***Beyond Policy – a real life journey of engagement and co-production to aid the recovery journey***

***Introduction***

How do people who have multiple disadvantages have a real say and influence within health policy and create equity at all levels as an aid to the recovery process? The service user movement has been around for some years and is now starting to gain momentum, but with one important caveat – health and social care professionals and policy makers in the main continue to create a tick box involvement culture and many although without malice do not really understand the importance of a person with lived experience of disability both mentally or physically being included in all aspects of delivery, policy and development.

***Method***

This is taken from an international multi-authored publication from a personal journey of "recovery in mental health". One example is of a researcher not having a fundamental grasp of why they should create equality within a research team when users are a 'core' part of the group. They are not, and indeed are somewhat treated as if they should be grateful to be there. Where does this come from? In the main, and in this instance, institutional inequality and lack understanding of the principles and practice in which individuals can make a full and marked difference within academia and within health research and policy development.

***Results & Discussion***

Many sections of our society have had to campaign and fight for their rights over the centuries from slavery, to gay, lesbian, bisexual & transgender people to mental health issues and physical disability, and why?. How does this affect recovery and what is the best practice for co production to reframe a recovery journey for the individual? This paper asks and tries to answer those questions from a personal journey of recovery and health inequality.

**Parallel Session 1.5**
**Theme: Allocating resources**
**Room: LT6**

**Ashley-Christopher Fallon**

**"My recovery journey, with me in the driver's seat" – helping forensic service users engage with the service model**

***Introduction***

National policies and clinical activity within forensic services work in a complimentary manner to aid forensic recovery, however engaging service users presenting with extreme mental health and risk profiles can be challenging - especially when delivering complex forensic models of care. In order to encourage the uptake and meaningful delivery of patient-centred care, one forensic directorate within a mental health Trust committed to a collaboration strategy with service users in order to deliver education and provide engagement opportunities for service users side by side with service users. This was entitled by service users as the "SCALE Roadshow strategy".

***Methods***

Eight "SCALE Roadshows" were delivered across three medium secure hospitals within a three month period. These utilised service user accounts, language and innovation to communicate the eight programmes within the directorate's model of care known as "SCALE", using video, leaflets, spoken word and art. Multi-disciplinary teams co-produced and co-delivered information and presentations in an interactive open-day format which demonstrated the value of engaging in specific forensic recovery-focused activity e.g. risk reduction, mental illness etc.

***Results***

Approximately 187 service users engaged across the Roadshows. Of the activities, 40% of the service users described enjoying the SCALE plotter activity the most (plotting the recovery journeys of famous film characters), 30% the SCALE programme stalls, and 30% the recovery stories. 80% of service users named one of the individual SCALE stalls as "very helpful" in assisting understand and engage with the service model. Since the Roadshows, the SCALE video has been used across the service, directorate and Trust to promote the model, including as part of direct clinical and forensic interventions.

***Conclusions***

With approximately 87% of the available service users attending the SCALE Roadshows were a successful way to reach many service users and promote the model of care in the service. Described as "encouraging" by service users, the SCALE Roadshows were also covered in the wider Trust's publications, recovery events and service user-led activities. By making the SCALE model more transparent and accessible, it remains clear that service users find engaging in complex treatments and services both motivating and achievable.

**Tanya Samuels**

**Exploring the potential to develop different service models to support people in mental health crisis**

***Introduction***

Emergency care for people in a mental health crisis falls short of physical health care and people are often unable to obtain the urgent and compassionate care they need. Responses will require service redesign involving a wide range of providers. Richmond Fellowship (RF) is a national UK mental health charity and support people in crisis by providing short term accommodation placements in a safe and homely environment, where individually tailored support is delivered to reduce distress, to develop coping strategies to help self manage their mental health and avoid an escalation that could potentially lead to a hospital admission. Data is currently being analysed to better understand the people who use these services and explore the value of crisis houses as a feasible alternative during a mental health crisis.

***Methods***

We collected and analysed data from more than 600 people who used RF crisis houses to develop a profile of people, their diagnosis, needs, support areas, experience and impact of the service on their mental health. We also examined their use of mental health services after their placement in the crisis house.

***Results***

65% of people accessing our crisis houses were women. The four main reasons for entering were suicide ideation (22%), depression (17%), low mood (17%) and high anxiety (11%). 70% had an existing mental health diagnosis. Data showed that 19% presented to A&E and 14% at their GP during their crisis. 19% had a hospital admission in the year prior to using the service. Key support areas were sleep (59%), anxiety (58%) and low mood (50.5%). Less than 10% used the service more than once and just 11 cases resulted in later admission to hospital. More than 80% said the placement helped them develop coping strategies and to understand triggers to their crisis.

***Discussion***

We contact people 3 and 6 months after leaving the service to compare their use of mental health services prior to and after leaving crisis houses to explore if services have the potential to reduce use of other services for mental health and potentially prevent the future need for individuals to access acute hospital care.

**Rose Thompson**
**Implementing independent support brokerage and personalised support planning in traditional social care settings: lessons learned in a local council context**

***Introduction***

My Support Broker (MSB) is a social enterprise that engages independent support brokers, who have relevant lived experience of social care, to work in a social care context. Their central philosophy is to write innovative, personalised support plans that build on existing customer strengths and interests, rather than a traditional, deficit based focus on basic care needs. MSB supports customers to use personal budgets and to plan for their social care needs to 'live their best life', in contrast to traditional support provided on a traditional, block contract basis. Implementation of this approach in a council setting with existing 'traditional' working practices can be challenging.

***Methods***

This was a co-produced evaluation. Two of the researchers had lived experience of using health and social care services. The approach was qualitative and involved interviews with a range of participants: MSB customers; Staff from MSB; Support brokers; Staff from two Partner Local Councils.

This presentation will explore how independent support brokerage was implemented within two local councils.

***Findings***

Enablers:

- Councils were aware of the legal imperative to implement personalisation created by the Care Act 2014
- Strong commitment to personalisation and independent support brokerage at strategic levels of the councils

Challenges:

- Not all plans were implemented by local councils
- Differing understandings of what may constitute relevant 'lived experience' of social care support services across stakeholders
- Logistical challenges in relation to existing working practices and the provider landscape
- Poor partnership or possibly active resistance to working with independent support brokers

***Conclusions***

Independent support brokerage represents a shift in power and control over resources from councils to individuals with support needs and their families, and thus is aligned with recovery philosophy. Implementation of independent support brokerage is challenging, require existing working practices to change, and may be met with active resistance in some circumstances.

**Li-yu Song**
**The usefulness of the strengths model in facilitating recovery: the participants' perspective**

***Introduction***

The investigator launched a three-year experiment by adopting the strengths model to facilitate the recovery of persons with psychiatric disability (hereinafter called consumer) and their family caregiver. Five community psychiatric rehabilitation agencies participated in this study. This presentation will illustrate the evaluation of the participants on the model.

***Methods***

This study adopted a qualitative approach through in-depth interviews. The interviews were conducted six months after the inception of the experiment and 18 months after. Each time ten consumers and nine caregivers receiving services were interviewed. In addition, 7 consumers and 10 caregivers were interviewed when they left the service either with positive results or for personal reasons.

***Results***

The majority of the participants expressed positive views of the model. Few revealed negative experiences. The most impressed and positive aspect was the collaborative relationship between workers and the participants. For consumers, the positive aspects in services were: stimulating ideas and hope, providing support, as well as fostering skill learning, social inclusion, setting goals and using social resources. The services that the caregivers felt impressed were: providing psychological support and counselling, helping caregivers to understand their family members' situation, and learning coping methods. The strengths assessment helped them to aware their positive aspects and potentials. The personal planning was a guide for actions and helped the participants to achieve goals. Yet, one consumer thought that the assessment was too formal. The participants revealed some unmet needs, including more support, more options, helping them to understand mental illness and s elf help, and more financial assistance and occupational services.

***Discussion***

The model could help the participants to regain autonomy, set goals, and take responsible actions. However, for some, they need more time and resources to go through the recovery process.

**Mathilde Labey**

**Health democracy and recovery oriented practices: a French experience in mental health**

Rooted for 40 years in a territory of 85.000 inhabitants, our mental health public service is engaged in community mental health principles and develop recovery oriented practices. The actions taken imply prevention, linked with local policies, but also a concrete change in daily practices. The reorganization of our system allowed deinstitutionalization : 80% of the budget is allocated to ambulatory care, home-based care, with respect of users environment, autonomy and self-determination. We work on policies and organization aimed at reducing compulsory treatment. Our 10 beds for hospitalization (compared to a national average of fifty for the same scale) are located in an open service, in a general hospital building, with no seclusion rooms, and with an objective of « zero restraint ». Since 2012, in addition of specific recovery oriented tools (advance directives, crisis plans, digital support for autonomy called « Barometer »), we fostered and valued experiential knowledge through 3 actions:

- Foster mutual support. We took part in the national peer-support workers programme, first to be employed and paid as peers in mental health (2 peers in the service, and 3 to be hired)
- Develop health democracy : forums organized in the service, elected spokespersons who participate in organization meetings, working groups, management of suggestion and complaint forms (4 users elected as spokespersons in the service)
- Train professionals with users, experts of their own experience, and local users associations

Our presentation will detail the transformation of the service and the development of these concrete practices, and so illustrate the transition from a concept to a reality.

**Parallel Session 2**
**Tuesday 19 September**
**10.00am-11.00am**

**Parallel Session 2.1**
**Theme: Recovery for different groups**
**Room: LT2**

**Sally Barlow**
**Barriers to and facilitators of recovery-focused care planning and coordination in UK mental health services: findings from COCAPP and COCAPPA**

***Introduction***
We aimed to examine factors helping and hindering collaborative, recovery-focused, personalised care planning and coordination in UK community and inpatient mental health services.

***Methods***
COCAPP and COCAPPA used comparative, cross-national, case study designs. Data were generated in six NHS organisations in England and Wales. 749 users of mental health services and 491 professionals completed measures. 193 service users, carers and staff were interviewed. 84 care plans were reviewed, and 12 review meetings observed. Survey data were analysed descriptively and inferentially and qualitative data were analysed using the framework method.

***Results***
Key results and findings from the community (COCAPP) and hospital (COCAPPA) studies will be presented and compared. Across the two studies, different understandings of recovery, the bureaucratic requirements of care planning, pressures on staff availability and time, and the ability or willingness of service users or staff to engage in collaborative working could all inhibit recovery-focused care planning and coordination. Good therapeutic relationships, continuity of contact and more individualised approaches enhanced the recovery-focus of care. Inpatients were aware of efforts to ensure their safety but in both hospital and community settings, discussions of risk rarely involved service users or carers.

***Discussion***
Service users value their relationships with staff. Administrative and organisational pressures mean that care planning and coordination often fail to deliver on expectations. Different understandings of recovery within and between groups may impair efforts to be recovery-focused.

**Lea Gaulshøj Thomsen**
**How to deal with sleeping difficulties when this is only one difficulty among many**

***Introduction***
The project is located in Denmark, more specifically in the organization: Social psychiatry for adults in Region 'central Jutland' in Denmark. The aim of the project is to provide improved sleeping opportunities for the residents at the six social psychiatric group homes in our organization. Furthermore, the hope is that the results can help others with sleep difficulties and/or psychiatric disorders. Sleeping difficulties for people with psychiatric disorders is often explained as a symptom of their disease/disorder for which reason it cannot be treated separately before the disease/disorder is treated. The aim of this project: what happens to the psychiatric disorder if we work determined and distinctly with the sleeping difficulty? Our hope and hypothesis is that it will ease the psychiatric disorder's hold on the individuals and contribute positively to Recovery. We have just finished the preliminary phase of the project. In this phase, we have investigated which interventions regarding sleep that are the most promising.

***Methods*** of the first phase of the project:

- A literature review
- Anthropological field work/participant observation
- Interviews with employees and leaders
- Workshops with those residents who wished to join
- Networking with possible stakeholders in the next phase of the project

***Results*** in the first phase of the project:

- It is very relevant to address sleep difficulties separately, because of neurological reasons
- It is a relevant hypothesis to continue addressing; that working directly with sleep difficulties will heighten the residents' functioning level and psychological well-being and thereby maximizing their chances of recovery
- Alone by bringing up this theme with the residents, heighten their motivation and agency regarding trying to solve these difficulties
- It is important to heighten the professional level of knowledge regarding sleep. It is just as important to respect the specifik person's experiences, motivation and wishes when looking for one or more relevant interventions.

***Discussion***

- What are your experiences regarding professional work with sleep difficulties?
- Do you have (co-creating) ideas for the next phase of the project?

**Carina Teixeira**
**Peer support providers in the United States mental health services and systems**

***Introduction***

Peer support services have grown in the past two decades and are now an integral part of mental health services and systems nationally and internationally. Given the burgeoning role of peer supporters in the mental health workforce, and the field's commitment to hiring and retaining peer support providers, it is critical to understand how they fare in the workplace, how they are trained and supervised, their work roles, and their level of satisfaction.

***Methods***

We undertook an online survey to better understand the roles, work tasks, stressors, and sources of satisfaction among this emerging workforce. We recruited a national sample of individuals who identified themselves as peer support providers. A total of 608 participants completed the survey, of which 597 responses were used for these analyses.

***Results***

Analyses suggested that individuals in the US identifying themselves as peer support providers (or similar title) work in a wide variety of settings and spend the majority of their work time providing direct peer support. However, a significant number of individuals also reported performing non-direct peer support tasks such as administrative work and supportive tasks which are outside of their core roles. Peer support providers reported a significant lack of recognition in their roles, a lack of collegial respect, and ambiguity in their roles. However, many peer specialists do report high levels of satisfaction with their jobs. Average compensation ranged from $10 to $20 per hour.

***Discussion***

Results of this survey provide critical information about the expanding role of peer providers in the mental health arena. These data should be useful to determine the best ways to support peer providers in the workplace in order to reduce turnover and turnover intention, to reduce sources of stress on the job, and to increase job satisfaction and support good job performance.

**Parallel Session 2.2**
**Theme: Recovery for different groups**
**Room: LT5**

**Corinna Hackmann**
**Attachment in mental health peer support: A realist review perspective**

***Introduction***
A lack of clarity of the mental health peer worker role has been linked to inconsistent findings of effectiveness and role confusion both from the perspective of peers and the services that employ them. The aim of this realist review was to synthesise the literature to gain a better understanding of what works, for whom, in what circumstances and how?

***Method***
The research team included a psychologist, two peer support workers, and two academics. The literature was synthesised to develop a programme theory relating to the outcomes that peer workers achieve, the contexts and activities that are linked to these and the mechanisms of change that underlie the relationship between context and outcome. The review focussed on relationship factors between peer and service user as initial iterations of the data analysis suggested that this was critical.

***Results***
Over 10,000 articles were screened and 28 included in the final analysis. The process of data extraction and analysis was iterative. Final iterations included feedback from a group of peer workers. The findings suggest that attachment may offer a useful framework for conceptualising the contexts and outcomes linked to peer work and an insight into the mechanisms of change underlying these. Experiencing a consistent, safe and trustworthy relationship could contribute to the updating of beliefs and expectations relating to the self (in terms of being worthwhile and effective) and relationships (connectedness both with peers/MH services and the development of social networks).

***Discussion***
This literature synthesis offers a better understanding of the outcomes that mental health peer workers achieve and the contexts that are linked to these. The focus of the review was on relationship factors and the findings suggest that models of attachment may offer an insight into underlying mechanisms of change.

**Sandra Jayacodi**
**CNWL's SHINE Project: Working with service users to develop new approaches to physical health care in mental health services**

***Introduction***
People with serious mental health difficulties have a significantly reduced life expectancy relative to the general population. Numerous evidence-based guidelines and policies designed to improve their physical health care have been published, but there remains a gap between these recommendations and practice. The SHINE project brought together a team of service users, quality improvement (QI) experts and healthcare professionals to systematically improve the physical health care of patients admitted to a mental health ward. Key to this was the development and implementation of a comprehensive physical and mental health assessment tool. People with lived experience were central to the project from the outset, guiding the formulation of overall project aims, and focusing on how health information was fed back to service users to promote meaningful choice. This led to the development of a new individualised physical health plan and new courses delivered through our trust Recovery College.

***Methods***
Working with NIHR CLAHRC Northwest London we adopted key QI methods including the construction of an action-effect diagram, process mapping, and the use of plan-do-study-act cycles. We used the national 4PI standards to guide our approach to service user engagement, and have been cited as an example of best practice in this respect.

***Results***
Rates of physical health assessment increased from 81.3% to 96.9%, while recording of

body mass index increased from 21.55% to 58.6% and from 22.35% to 75.9% for systolic blood pressure. Qualitative assessment of the user experience of our intervention and courses is ongoing.

***Conclusion***

Having demonstrated that a systematic QI approach can support clinical teams to successfully and sustainably implement guidelines on physical health care in an acute mental health setting, we propose that this is also feasible in other acute and community mental health settings and are seeking to roll out our work in a further funded round of our project.

**Mary Birken**

**Feasibility study of a recovery orientated intervention following discharge from hospital to promote participation in daily life**

***Introduction***

People with a personality or mood disorder have identified that being involved in meaningful activities and structuring their daily routine are important dimensions of their personal recovery. However, approaches to support the ability to carry out these activities have been less well described as approaches to promote personal recovery. A recently developed occupational therapy intervention called "Graduating Living skills Outside the Ward" was tested with people with a diagnosed personality or mood disorder following discharge from hospital to support their participation in daily life outside of hospital. The intervention has the potential to reduce use of crisis services and promote personal recovery.

***Methods***

A pre-test post-test design was used to evaluate the intervention. Use of time, social functioning, quality of life, use of crisis services and hospital admissions and their associated costs were measured before and after the intervention, and four months following completion of the intervention.

***Results***

Twenty two participants took part in the study. The participants increased their participation in meaningful activities at the end of the intervention and maintained this at follow-up. The participants on average, spent fewer days in hospital and used less community crisis services at the end of the intervention and at follow up. Cost analysis showed that savings were made following the use of GLOW.

***Discussion***

The intervention, GLOW, shows promise of being clinically and cost effective for people with a personality or mood disorder to sustain their time in the community and promote personal recovery. This study adds to the body of knowledge regarding interventions to prevent long term disability and add an occupational perspective to the evidence regarding supporting personal recovery for people with a personality or mood disorder.

**Parallel Session 2.3**
**Theme: Re-situating recovery**
**Room: LT4**

**Samantha Adkins**

**Understanding the 'layers' of Recovery Education**

***Introduction***

The Dorset Recovery Education Centre has been offering courses since 2012. The partnership between Dorset HealthCare (DHC) and the Dorset Mental Health Forum (DMHF) who deliver the Recovery Education Centre developed layers of Recovery Education, with a view to enable more people to have access to Recovery Education. These sit outside of the Recovery Education Centre but are guided by principles of co-production and recognise that people and communities hold their own solutions. Part of

the learning, in Dorset, is that 'one size does not fit all' and further to this, offering recovery education in different settings goes some way in addressing recent criticism around recovery colleges and the importance of meeting a broad range of needs.

***Methods***

A mixed approach was used in order to try and gain a full understanding of Skills Workshops and the Community Mental Health Pilot. This included attending a series of workshops, discussions with staff and those who accessed the workshops.

***Results***

Benefits of Recovery Education across the 'layers' included dedicated time for Peers to share their own expertise in theoretical frameworks, skills, and techniques. For services the Recovery Education model provided an example of valuing the bringing together of professional knowledge and lived experience expertise.

***Discussion***

Recovery Education models rely on co-production however supporting the implementation of this way of working has been challenging. The importance of shared values, vision and aims when working in partnership with others and in particular in being able to recognise both your colleague and the students in the class as assets was a key learning point in both 'layers' of Recovery Education. The evaluations provided an opportunity to be able to articulate some key features of more traditional education and how that might feel different.

**Louise Niven**

**Adopting Recovery Orientated Care in a small inpatient unit in the Kingdom of Saudi Arabia**

We will report on our attempts to adopt a recovery approach to care in a small in patient mental health unit in Saudi Arabia. We are currently running recovery workshops for 11 members of the multidisciplinary team. To the best of our knowledge this has not been done before in the Middle East. We therefore offer a unique perspective on recovery. The program has drawn on the theories of change management. The program consists of 8 recovery themed sessions. Sessions are activity based and have been designed to encourage group cohesion and reflection. The program is being evaluated using Participatory Action Research. We are running focus groups to collect data. The data will be analysed by the end of June.

**Louise Hunt**

**Running in the family**

A mother and daughter with experience of the impact of trauma within 3 family generations, we have both been users of psychiatric services but have redefined what recovery means for us and resituated it within the context of our own lived and inter-generational experience and within a family social economic and political context. We discuss research we have done individually and together to make sense of our journey through services, to identify the causes of both our distress and dysfunctions which collectively led to many labels being given to each of us and we mention the research we continue to conduct to maintain our well-being through alternative therapies, balanced nutrition and peer activities.

***Methods***

We used phenomenolical narrative production and qualitative analysis with support from a peer-led organisation, our own literature and on-line searches and subsequent peer focus group discussions. We never set out to be researchers but we have become tireless investigators and knowledge makers as we defined and resituated our own recoveries.

***Results***

are very liberating although disheartening at times where we identified past needless distress along our individual and joint recovery journeys. We now see ourselves as people with expert knowledge of our own conditions and how to manage them and we view our experience as product of external context and situation rather than a set of symptoms. We are disseminating our findings through teaching within local universities as a mother-

daughter survivor team.

***Discussion illustrates***

- how dangerously easy it is to label a working class mum as 'mentally unbalanced' and a neglectful parent when careful investigation would have revealed both dyslexia and dyspraxia (only just diagnosed at age of 23!) in the child who was 'failing to thrive' and so needed to be placed in care
- how easy it is to diagnose a traumatised survivor of abuse as bi-polar and incurable - to be made fit for society through heavy meds, the struggle entailed in achieving a drug-free recovery, and how resituating recovery unlocks unrecognised capacity and potential
- how the mental distress and / or well-being of people within a family can interact and compound with positive or detrimental consequence.
- and finally how being believed in, validated and supported by peers and by 'humanising practitioners' can enable a return to well-being undreamed of within the medical case notes and permit a working class mum to redefine herself as a change agent, recovery champion and researcher.

**Parallel Session 2.4**
**Theme: Prevention of mental ill-health**
**Room: LT1**

**Kate Nurser**
**A qualitative exploration of Telling My Story in mental health recovery.**

***Introduction***

Creating more positive individual narratives around illness and identity is at the heart of the mental health care recovery movement. Some recovery services explicitly use personal storytelling as an intervention. This paper looks at individual experiences of a personal storytelling intervention, a recovery college Telling My Story course.

***Methods***

Eight participants who had attended the Telling My Story course offered at a UK recovery college were interviewed. Data were analysed using Interpretative Phenomenological Analysis.

***Results***

Five key themes emerged: "emotional potency", "feeling safe to disclose", "renewed sense of self", "two-way process" and "a novel opportunity".

***Discussion***

The findings suggest that storytelling can be a highly meaningful experience and an important part of the individual's recovery journey. They also begin to identify elements of the storytelling process which might aid recovery, and point to pragmatic setting conditions for storytelling interventions to be helpful. More time could be dedicated to individuals telling their story within UK mental health services, and we can use this insight into the experience of personal storytelling to guide any future developments.

**Shulamit Ramon**
**Shared decision making as a co-produced preventive self management strategy: A UK case study**

***Introduction***

Shared decision making (SDM) between citizens using mental health services and clinicians is based on the evidence and belief in the value of sharing both experiential and scientific knowledge as essential to making sound intervention decisions jointly. This presentation will look at an action research project on SDM in a UK mental health trust focused on psychiatric medication management in working with people experiencing long term mental health difficulties.

***Methods***
Uniquely, service users were involved as co-trainers, management group members, and co-researchers alongside researchers, care co-ordinators and psychiatrists. The training was delivered to parallel groups of service users (47), care co-ordinators (35) and psychiatrists (12). Evaluation took place at baseline and 12 months after the completion of the training by applying validated measures of conflictual decision making, mental health recovery, therapeutic alliance, cost effectiveness analysis, anonymous feedback, and semi-structured interviews.
***Results***
Service users and care co-ordinators were largely satisfied with the training, while psychiatrists expressed more reservation about it. Service users reported a significant reduction in conflictual decision making and an increased application of SDM in their meetings with prescribers. The cost effectiveness analysis showed reasonably good outcomes. Care co-ordinators reported reduced fear of work on medication management. Most psychiatrists did not report any change.
***Discussion***
SDM and the training for it can be co-produced and enhances self management. The construction of the training by both service users and providers, and the co-leading of the training groups went well. The Trust adopted SDM as its policy across all pathways, and consequently steps were taken to implement SDM in everyday practice, meeting varied levels of success. Barriers to effective SDM in practice and the limitations of the study will be highlighted.

**Noami Hadas Lidor**
**Training for Shared Decision Making (SDM) as a Co-production: An Israeli case study**

***Introduction***
For the past twenty years, Israel has been going through a process of decreasing MH hospitalization and increasing the possibilities for service users in the community. Israel has adopted the Recovery Concept which enables the service users to live in the community. This presentation describes the project that took place in the past two years in Israel and consisted of two SDM training programmes, one for mental health rehabilitation workers, and one for MA students in OT. Each student had to submit a report and an analysis of their work with one service user with whom they practised SDM and applied at least one of SDM aids over a period of three months. The trainer was an experienced MH professional and researcher.
***Results***
Participants expressed a high level of satisfaction and reported a good level of participation in SDM by the service users with whom they worked. The reports showed mostly positive developments between the first and the second meeting. Although service users were not co-leading in this project, examples of the crucial value of their involvement were given in the forms of research results, videos and role play. Some of the participants were themselves service users as well as workers. The enthusiastic reception and application by the participants was a pleasant surprise to the UK based trainer and requires further analysis.
***Discussion***
The uniqueness of the project in Israel was that participants included social workers, occupational therapists, service users and psychologists, and the issues that they dealt with were day to day rather than medication or their medical status. It was very interesting that the enthusiasm of the service givers and the service users were both very high. Both said that it influenced the relationship between them for the better.

**Parallel Session 2.5**
**Theme: Allocating resources**
**Room: LT6**

**Rebecca Murphy**
**Peer-led mental health support in Ireland: Delivering on personal and clinical recovery**

***Background***
Over the last three decades, peer-led mental health supports have rapidly developed across the world and are now supported by a growing body of evidence that they produce comparable recovery outcomes to their counterparts in non-peer run mental health services. However, peer-led initiatives remain under-developed and under-researched in Ireland leading to a dearth of local evidence from which to support their future growth.

***Methods***
A multi-method approach was employed. Working in partnership with two peer researchers, qualitative and quantitative data were collected from people with self-experience of mental health difficulties who attended two of the longest running peer-led mental health services in Ireland. In total, 139 people completed the survey and 21 people participated in focus groups.

***Results***
Participants reported that the peer-led services had positively impacted on their personal and clinical recovery. On a scale of 0-7, participants rated the projects' impact on all items associated with their personal recovery above 5, including a sense of belonging (M=5.69), hope for the future (M=5.69), sense of ownership of recovery (M=5.67), sense of purpose (M=5.59), self-worth (M=5.56), self-confidence (M=5.51), and self-empowerment (M=5.43). Over half of participants also reported a reduction in the symptoms of their mental health difficulties (53.8%). Further, just over two-fifths reported a reduction in hospital admission (43.9%) and attendance at mental health services (43.9%) and just under two-fifths reported a reduction in GP attendance (39.7%). Approximately, 34.9% reported a reduction in their use of medication.

***Discussion***
Study findings suggest that peer-led mental health services are an integral component in supporting people's personal and clinical recovery journeys and as such should be adequately resourced to flourish as a vital complement of a recovery-oriented mental health service. To achieve this, the growth of existing and new peer-led initiatives must be nurtured by enduring commitment to the ethos of peer-led support and long-term fiscal support.

**Vrinda Edan**
**PULSAReveryday - a consumer led project**

***Introduction***
In previous studies exploring recovery oriented practice have identified that a lack of focus on consumers understanding of recovery may have a potential impact on the outcomes of recovery oriented practice. During the PULSAR project (presented in other papers) there came an opportunity to support a consumer led project to develop materials for consumers to sustain recovery and support them in leading discussion about what's important in their interactions with health and other service providers.

***Methods***
An expanded Lived Experience Advisory Panel (LEAP) was developed to oversee this project. Two consumer researchers were employed, and the consumer academic, Vrinda Edan, led the project. A literature review was undertaken and the results of this discussed at LEAP meetings. Preliminary material was developed and used at two focus groups, conducted by the consumer researches, to determine the final materials to be developed.

***Results***
During the focus groups to develop the material suggestions were made regarding the

potential of a group's process to deliver the material. A consumer guide was developed, as well as some supporting materials, and a four-week program to deliver and discuss the various domains of recovery as covered in the guide.

***Discussion***

This presentation will discuss the development, implementation and evaluation of the materials for this project. The unique composition of the work team will also be discussed highlighting what it means to be a consumer working on this research project and the value of supporting consumer-led participation research.

**Caroline Clarke**

**The challenge of developing recovery oriented services in secure settings: My Shared Pathway as a framework**

***Introduction***

Adoption of the recovery approach has proved challenging in forensic services, which have traditionally been dominated by the medical model and concepts of security and risk. 'My Shared Pathway' was developed as part of the Government Quality Improvement, Productivity and Prevention (QUIPP) programme to provide a framework for promoting recovery, increasing transparency and reducing admission times. The aim of this study was to explore the lived experience of 'recovery' for low secure service-users.

***Methods***

Interpretive phenomenological analysis (IPA) was used to capture the subjective meanings that a 'convenience sample' of six male participants ascribed to this process.

***Results***

Participants discussed the My Shared Pathway initiative as a helpful framework for embedding recovery principles. Five superordinate themes were identified: It's a journey; We're vulnerable in here; Relationships with staff; Loss; and Hope. These findings are consistent with those seen in the forensic recovery literature and suggest that My Shared Pathway helps promote recovery in a number of ways. Participants found the programme helpful for collaborative care planning; however, the workbooks and linked interventions were seen as the province of the psychology service rather than becoming embedded in the culture of the unit for use by all staff.

***Discussion***

Without the commitment to truly embed it across secure services, and provide that standardised care that the framework set out to achieve, My Shared Pathway lost its momentum, leaving frontline staff with the perception of a labour intensive target driven service that had lost all clinical meaning. It appears that the issue of how recovery in secure services will be supported continues to present a challenge. Staff-training may prove helpful in facilitating this, however; this is not a lesson that stops in the classroom. Recovery principles need to be embedded within our services if we are to create a recovery focussed culture.

**Parallel Session 3**
**Tuesday 19 September**
**11.30am-12.30pm**

**Parallel Session 3.1**
**Theme: Recovery for different groups**
**Room: LT2**

**Kelly Elsewood**
**A novel and inexpensive approach to fostering hope for recovery for people with complex mental health difficulties using 'experts by experience'**

***Introduction***
Stories from peers or 'experts by experience' give an insight into the process of 'recovery' that can offer inspiration to people who experience mental health difficulties. Fostering inspiration and hope can be a particular challenge in inpatient mental health settings. We developed a group intervention aiming to foster hope and inspiration for recovery among service users, by using the stories of 'experts by experience'. For practical ease and resource considerations, all stories were sourced from blogs or videos on the internet.

***Methods***
Service users on a specialist inpatient ward for women with difficulties associated with emotionally unstable personality disorder were invited to 14 weekly group sessions. The sessions showed selected videos/blogs featuring 'experts by experience', each describing their personal approach to recovery and/or experience of overcoming adversity. A facilitated discussion followed each viewing, which sought to elicit the views and reflections of group participants. Responses were recorded and then analysed using thematic analysis. Service user feedback was elicited with a post-intervention questionnaire.

***Results***
In total twelve individuals attended the sessions. The findings and implications of the thematic analysis will be presented. 6 participants completed a questionnaire. All respondents reported finding the intervention 'validating' and 'worthwhile'. 4/6 reported that the group made them feel inspired to overcome adversity, one stated "it was good…finding out that it is possible to recover". As a result of the intervention, participants decided to co-produce a scrapbook video to illustrate their shared wisdom from discussions. This 2 minute video will be presented.

***Discussion***
A group intervention using 'experts by experience' via blogs and online videos, along with facilitated reflective discussions, was shown to be a well-received and low cost approach to fostering hope for recovery among people with long-standing complex mental health difficulties. Further reflections and implications for developing the intervention will be presented.

**Elizabeth Hughes**
**"Sex- the elephant in the room" Supporting and promoting sexual health in mental health recovery**

***Introduction***
Sex is a subject often ignored or avoided in mental health care. However, its an important aspect of peoples' lives and important as part of overall recovery. There is evidence that people with serious mental health problems have significant needs in term of their sexual health; expressing their sexuality; and in intimate relationships. This presentation aims to argue that sex is the forgotten yet important component of mental health recovery, and will report on a new study which aims to address these issues. This presentation will be co-produced by people with lived experience who have played a significant role in the development of the proposal as well as design and implementation of the study.

***Methods***
The RESPECT study is a feasibility randomised trial of a specifically developed

intervention to promote sexual health funded by NIHR. The purpose of the study is to establish parameters for a full trial and establish feasibility- i.e can it be done. The aim is to recruit 100 people from 4 mental health trusts in England, and half will be randomised to receive the 3 session sexual health promotion intervention.

***Results***

We will report on the feasibility outcomes including engaging community mental health teams in the study, recruitment methods, as well as numbers recruited and retained in the study.

***Discussion***

Sex is an important aspect of life and people with mental health problems have a right to a healthy and satisfying sex life. We challenge mental health services to be truly holistic in their approach and consider how the findings of the RESPECT study could inform practice around sexual health in the future.

**David Rosenberg**

**Obstacles and possibilities for implementing SDM in Swedish mental health services; Supporting interactivity and participation**

***Introduction***

Despite Swedish health care policy, which emphasizes patient participation in the planning of health care services, few programs have concrete methods for achieving this goal. Previous studies have shown that staff attitudes and systems which maintain power differentials, create obstacles for achieving participation despite methods such as SDM. The purpose of the study was to explore implementing SDM with an interactive digital decision tool, designed for users in community mental health services in Sweden. The tool was specifically developed, in collaborative research with users, to overcome disempowering experiences as they attempt to participate in treatment decisions.

***Method***

A process evaluation design (Moore et al. 2015) was utilized in order to investigate obstacles and possibilities for a structured intervention to facilitate participation in decision making. The design utilized in the study included collecting qualitative and quantitative data focused on three identified evaluation components; Context, Implementation and Mechanism of impact.

***Results***

Staff considered that SDM was most appropriate for formal treatment planning and that the use of the digital decision tool, which enabled interactive communication between staff and users, did support the user to be prepared for decisions, as well as helping staff to stay focused on user wishes. SDM was most often used voluntarily by each staff member, based on their experience and attitude, rather than a common practice for the service. Another barrier concerned capacity, with staff sometimes feeling they did not have formal power regarding treatment planning decisions, and expressing doubt as to the patient's willingness and ability to participate in decisions.

***Discussion***

The results suggest that contextual barriers to implementing shared decision making can be addressed by utilising interactive decision tools which concretely structure the interaction between users and staff and are connected to formally required treatment planning processes that are essential for user participation.

**Parallel Session 3.2**
**Theme: Recovery for different groups**
**Room: LT5**

**Fay Jackson**
**Why not a peer worker?**

***Introduction***

Flourish Australia (previously RichmondPRA), a large community managed organisation supporting people with MH issues, has demonstrated its authentic values by dramatically increasing its Peer Workforce through a strategy they called “Why Not a Peer Worker?”. Flourish Australia will share how the growth in their Peer Workforce has occurred and demonstrate the positive impact a large number of trained and supported Peer Workers has had on all service stakeholders including:

• People accessing the service
• Families and Carers
• Peer Workers
• Other staff
• Service partners

The aim of the strategy was to substantially increase the Peer Worker numbers; produce a high quality, valuable and valued Peer Workforce and to improve the services offered to people with lived experience accessing their service.

***Methods***

Through a review and rewriting of policies, research and crucial conversations at all levels of the service, from the Board through to people accessing the service, a decision was made to dramatically increase our Peer Workforce. In May 2015 Flourish Australia launched the “Why Not a Peer Worker?” Strategy and supporting program of: (i) Recruitment; (ii) Education/training; (iii) A Community of Practice; (iv) Mentoring, and (v) a Communications Strategy for all stakeholders.

***Results***

Flourish Australia has 700 staff, 50% proudly identify as having a lived experience of mental health issues and recovery. A significant proportion are Peer Workers. As a result of the "Why Not A Peer Worker Strategy?" Flourish Australia has grown their Peer Workforce from 22 to 140 Peer Workers in a period of 18 months. This recruitment has been a major contributory factor to improving the delivery of recovery focused services.

***Discussion***

Flourish Australia will share the challenges and methods used to overcome obstacles to growing a respected, values driven, recovery focused Peer Workforce. They will challenge you to ask “Why not a Peer Workforce?”

**Mang Wun Hung**
**Peer Mentor Program: An innovative recovery-oriented service for psychiatric patients in Hong Kong**

***Introduction***

Peer support is a key principle in the recovery model of providing mental health service. It is to describe the engagement of people with lived experience in helping others to progress in their recovery journey. Recent years, recovery-oriented practice has been promoted in mental health services of Hong Kong public hospital settings. Peer Mentor program has started in Occupational Therapy Department of Pamela Youde Nethersole Eastern Hospital since Nov 2012. The program aims to 1) Empower discharged patient to develop competences as an activity mentor, 2) Instill hope of psychiatric in-patients through modeling; and 3) promote responsibility for recovery and mental wellbeing. Until December 2016, a total of 20 peer mentors (PMs) were recruited. They organized therapeutic groups such as Putonghua, Knitting, Cooking, and Chinese Qigong Ba Duan Jin for in-patients. Over 350 group sessions and 3000 attendances were attained from 2013 to 2016.

***Methods***
Patient satisfaction survey for all therapeutic activities conducted every year. Two focus groups are organized with peer mentors (PM) and participants separately to solicit more in-depth opinions for qualitative analysis.
***Results***
In the patient satisfaction survey 2016, Chinese Qigong ranked the third over twenty activities, and knitting class was selected as the most popular group activity. 9 PMs joined the Peer Mentor Focus Group and they expressed positive feedback on improving their self-esteem, autonomy and well-beings because of PMs feeling being empowered by utilizing their strengths to help others. For Participant Focus Group, majorities of them expressed to have increased hope on recovery journey under modelling influences.
***Discussion***
PM is a precious element in the recovery process of psychiatric patients. It activates positive change of patients and irreplaceable by any professionals. With encouraging feedback, the team of PMs will be expanded continuously. Besides, competent PMs can explore their suitability to be engaged in peer support workers in mental health service.

**Wing Kin Siegfrid LEE**
**Recovery-Oriented Practice in Occupational Therapy**

***Introduction***
With the launch of Hospital Authority Mental Health Service Plan for Adult in 2010, the model of service in Hong Kong has shifted to focus on recovery which promotes individualized patient-centred care to build up resilience and confidence, develop health lifestyle and pursue independent living in community. All psychiatric occupational therapy units have reviewed their service standard with Recovery Self-Assessment (User version) and Pamale Youde Nethersole Eastern Hospital ranks in the middle. “MY RECOVERY, MY ACTION” which embraces the important values and principles of Recovery Model is developed for our in-patients to facilitate their early discharge and better community reintegration through: 1) empowerment of responsibilities; 2) development of ability in managing illness, health and daily living; and 3) experience of personalized recovery goal-setting and increased autonomy in treatment choices. Various activities such as survey and focus groups, peer sharing, wellbeing groups and Love Living Love Yourself program are organized in our unit. Patients can enjoy the opportunities to express, design, participate and execute rehabilitative activities during recovery journey.
***Methods***
Single group pre-post measurement is designed to evaluate service effectiveness. Warwick-Edinburg Mental Wellbeing Scale, Hope scale, Canadian Occupational Performance Measure, and Illness Management and Recovery Scale were used & completed for each patient at intervals of pre and post program respectively.
***Results***
614 patients were recruited during 2013-15. Paired t-test showed significant improvements in their mental wellbeing (p=.000), illness management strategies (p=.000), hope (p=.000), performance and satisfaction of personal goal attainment (p=.000).
***Discussion and Conclusion***
Recovery-oriented practice appears to be an effective means to work with most of our patients as it promotes respect, self-determinant, individualized care and hope instillation. Patients can experience empowerment and development of sense of responsibility in their illness management and personal recovery. Occupational therapist can act as enabler to facilitate them to redefine their own health and life role.

**Parallel Session 3.3**
**Theme: Re-situating recovery**
**Room: LT4**

**Julia Lowes**

**"Spireites Active for Life" : Recovery & healthy lifestyle project in partnership with Chesterfield Football Club**

***Introduction***

Derbyshire Healthcare NHS Foundation Trust and Chesterfield Football Club Community Trust work in partnership to develop and deliver an innovative programme: 'Spireites Active for Life'.

***Method***

The programme consists of three 9 week cohorts which run throughout a 12 month period. This programme is part of a larger Mental Health strategy at the football club, which provides targeted Recovery opportunities for individuals with severe mental health problems. The aims of the programme are to motivate people to improve their mental wellbeing and physical health through adopting more active lifestyle. The course objectives are to help individuals learn about the benefits of a healthy and active lifestyle, understand what this means to them and support them to make positive lifestyle changes. The course is delivered using a football theme as a motivator to support behavioural change. For many of the participants this is the first step to overcoming their mental health problems, believing in themselves again, regaining self confidence in their own abilities and opening a door back into society. The project is co-facilitated by Chesterfield FC Community Trust sports coaches and Occupational Therapist from Derbyshire Healthcare NHS Foundation Trust plus other community partners. The programme is held at the Pro-act stadium home of Chesterfield FC. Peer supporters are involved in the development and facilitation of the group. The peer supporters become volunteers at the Football club.

***Results***

35 people completed the programme and weekly attendance was 8. Outcome measures used were :

• Warwick & Edinburgh wellbeing scale pre & post to measure mental wellbeing
• Physical screening pre & post BP, weight, BMI
• Goal attainment: personal goal were set weekly with longer term goal considered

***Discussion***

The project has led to further opportunities including match day "time to change" events. The course provides interdisciplinary learning opportunities for students from various specialties, including medical students, occupational therapy students and sports management students. Sheffield University third year medical students based in Derbyshire for their psychiatry placements are all timetabled to attend the course .This provides an excellent opportunity for medical students to get involved and experience different aspects of psychiatric management as opposed to the purely clinical approach often focussed on during their placements. The students were encouraged to fully participate in the activities with the aim of helping them build rapport and empathise with the difficulties many patients experience in their day-to-day lives. The informal feedback from medical students was very positive, with them enjoying undertaking the physical activities with the course participants. The project has run on non secured funding averaging £2600 per year.

**Mona Sommer**

**Lived experiences of support in the lives of young people with mental health problems**

***Introduction***

Support in different modes, expressions and actions is at the core of our public welfare society and in the field of mental health and recovery-oriented practices. Young people, who are not in school or work and struggle with mental health problems, often report that they do not receive the support they need. This study explore the meaning of support in a

phenomenological manner. Questions and aspects are defied from an experiential angle, by trying to examine 'support' as we live, practice and speak it in regular and professional relationships and in quotidian language. This project will add to the literature on first-person perspectives on social recovery.

***Methods***

We have interviewed 14 young people, age 18-25, and borrow their experience of the support, in order to explore the phenomenology of support. The analysis is carried out using van Manen's hermeneutic phenomenological approach.

***Results***

The experience of support seems inseparably connected to relational qualities of the relationship where support takes place. Support seems to be given and received in relations that provide for the other to be recognized and acknowledged. Attentive presence may be an entrance to an attitude of wonder, which is open to the otherness of the other – and hence, forms the basis for a supportive communion. Supportive support inhere qualities recognized in friendship and love. How the receiver of support experiences support as a relational quality cannot fully be preconditioned or planned. Support seems to be given to us as a human experience with characteristics that cannot be captured in rules, procedures and systematic regulations.

***Discussion***

The findings call for a critical view on current mental health practices and a broader understanding of high-quality practices. The study may contribute to the recovery field how to support young people in their personal and social recovery.

**Hilda Näslund**

**The role of mental health service user organisations in the post-deinstitutional era – a narrative literature review**

***Introduction***

In this narrative literature review we examine the role and challenges of mental health service user organisations (MHSUO) in the post-deinstitutional era. Current developments of mental health systems centrally affect MHSUOs, due to increased interest in MHSUOs as both service providers and as representatives in participatory processes. Together with internal developments of the service user movement this motivates our study. The concept of 'participatory spaces' guide our analysis.

***Methods***

This study employs narrative review methodology. We conducted searches in EBSCO and Scopus, scanned the references of the identified texts and performed hand searches to capture additional literature. 116 texts published from 2006-2016 were included and classified according to geographical context, publication year, methodology & main focus.

***Results***

Central to the role and challenges of MHSUOs in the post-deinstitutional era is their parallel presence in popular, invited and claimed participatory spaces. MHSUOs are moving through popular spaces, where alternative organizational models, practices and forms of knowledge can be developed. MHSUOs also occupy claimed spaces, where core practices of the service user movement are increasingly integrated into the professional service system and alternative services are provided. Furthermore, MHSUOs have been invited by authorities to new territories, by for instance participating in provisioning and policy formulation.

***Discussion***

Balancing political opportunities, as well as the risks, of different participatory spaces constitute central challenges of MHSUOs in the post-deinstitutional era. The current situation is marked by a shift in focus from gaining access, to critically examining political opportunities available in participatory spaces. We further discuss the importance of exploring 'geographies beyond psychiatry' in order to broaden the participatory agenda and strengthen community membership.

**Parallel Session 3.4**
**Theme: Re-situating recovery**
**Room: LT1**

**Simone Arbour**

**The implementation and evaluation of a recovery-oriented practice training module for service providers at a tertiary mental health hospital in Canada**

Although recovery-oriented practice guidelines have been launched in a number of national contexts including Canada, organizational transformation in terms of recovery-oriented practice has proven to be difficult. Canadian research regarding the challenges in implementing recovery-oriented practice outlines inconsistent staff training and the lack of adequate resources to fully realize implementation models as barriers preventing organizational transformation. Researchers in Ireland have also found that service provider knowledge about recovery has remained unchanged despite an increase in training and education. The current presentation provides an overview of the development and evaluation of a training module designed to enhance recovery-oriented practice at a tertiary mental health hospital in Canada.

***Method and Results***

The primary goal of the training was to shift clinician perspective from patient-centeredness to person-centeredness. Rather than focus on mental health diagnosis and tasks associated with clinical care, the training highlighted the importance of gathering information about the service user as a person to serve as a resource to enhance collaborative goal setting and personal recovery. Embedded within the service users' chart was a questionnaire designed to inform personal recovery facets of the individual. For example, it asks about what the service user is proud of; if they have any interests and hobbies; about their hopes for the future. Audits of the use of this tool (called My Story) revealed that most of the time, it was not completed by the clinical team. The implementation of the training was viewed as an opportunity to address this gap in recovery-oriented practice by both educating service providers about the concept of personal recovery and by highlighting the utility of the "My Story" tool in identifying opportunities to support the service user in identifying opportunities to enhance their recovery journey. Evaluation data of the training including the use of the "My Story" tool will be discussed.

**Ritsuko Kakuma**

**The PULSAR Project: What is the cross-cultural relevance of a mental health recovery questionnaire?"**

***Background***

In recent years, prevalence of mental illness has been increasing globally, and in Australia; and is very common among people from culturally and linguistically diverse (CALD) backgrounds. The Questionnaire about the Process of Recovery (QPR), a self-report instrument that measures personal recovery outcomes for patients of mental health services, is currently being used as the primary outcome measure for the Principles Unite Local Services Assisting Recovery (PULSAR) Project in the south-eastern region of Victoria. The extent to which the QPR is relevant among CALD communities in Australia, however, has not yet been evaluated.

***Objectives***

This pilot study aimed to examine the cultural relevance of the QPR. Methodology: One-on-one, semi-structured interviews were conducted with two general practitioners and nine consumers from two south Melbourne clinics in communities with a high representation of Iranian and Burmese clients. The consumers were asked to complete the QPR at the start of the interview to familiarise themselves with the tool before commencing the interview. Interviews were audio-recorded, transcribed, and translated where appropriate. Transcripts were analysed using thematic framework approach.

***Results***
While there was a general agreement that a tool to facilitate the discussion and assessment of recovery would be useful, the QPR needs to be modified to make it more relevant to CALD consumers. For example, participants' responses revealed different conceptualization of personal recovery and different levels of knowledge and understanding about mental health by consumers. Issues specific to CALD communities such as immigration status, language issues and different understandings of specific items of the QPR were identified as important considerations to improve the tool.
***Conclusions***
The QPR is potentially a useful and relevant tool among CALD communities but more work needs to be done in its adaptation to different cultures.

**Rebecca Toney**
**Development and evaluation of a fidelity measure for Recovery Colleges**

***Introduction***
Recovery Colleges (RCs) offer co-produced adult education for students with mental health problems. There are around 40 RCs in England. Only preliminary investigation of key components of RCs has been published. The National Institute for Health Research (NIHR) has funded the Recovery Colleges Characterisation and Testing (RECOLLECT) Study (grant RP-DG-0615-10008), whose aims include the development of a quantitative measure of fidelity to each critical dimension.
***Method***
The fidelity measure is being developed using a three-stage iterative consultation process. Literature review and consultation (RECOLLECT Lived Experience Advisory Panel, RECOLLECT International Advisory Board, ImROC consultants) have informed the development of a draft framework. In Stage 1, 10 RC managers in England will be interviewed about the draft framework. Thematic analysis of these interviews will characterise participants' understanding about the essential features of a RC, and identify refinements to the draft framework. A draft Fidelity Checklist to inform implementation of RCs will be developed. In Stage 2, managers (n=1), peer trainers (n=4) and service user students (n=10) in three sites (n=45 in total) will complete the Fidelity Checklist and a semi-structured interview about its comprehensiveness and acceptability. We will revise and finalise the Fidelity Checklist, and then adapt it for use as a single-informant Fidelity Measure rated by RC managers. We will ask all RC managers in England to complete this Fidelity Measure twice (two weeks apart), and to provide written feedback on usability.
***Results***
A preliminary draft framework developed following expert consultation comprises High-level understanding, Key dimensions, Measurable indicators, Sources of evidence and Key stakeholders. Results from the iterative development and evaluation of the Fidelity Checklist and Fidelity Measure will be presented.
***Discussion***
The Fidelity Measure will be used in a future grant application to allow investigation of the relationship between each dimension and student outcomes in Recovery Colleges.

**Parallel Session 3.5**
**Theme: Prevention of mental ill-health**
**Room: LT6**

**Susan Hogan**
**Film: Mothers Make Art**

In The Birth Project we are exploring women's experience of childbirth and the transition to motherhood using the arts and then presenting the research findings in films and exhibitions.
Our overarching questions are concerned to explore what role arts engagement might

have to play in antenatal and postnatal provision, especially where post-birth trauma is being translated into bodily symptoms. The Birth Project is also interested in exploring to what extent clinically-related birth practices are implicated in iatrogenic outcomes and post-natal distress. Furthermore, we are also concerned to investigate what is distinctive about an arts-based approach in terms of expressing narratives about the transition to motherhood.
Mothers Make Art, asks questions in two ways: what are the effects of participation in workshops for the makers of the art and then what are the effects on others who experience the art that is produced as viewers. The Mothers Make Art group comprised eight women who live in a city in the north of England. They self-selected to participate in a series of twelve workshops. Some of the women were trained in the arts, some not, but all had an interest in visual arts, and an openness to learn and to make. The brief was to use a participatory framework to enable the women to explore any topics they wished with respect to the birth experience and motherhood.

**Melissa Pyle**
**Evaluation of peer support training: impact on empowerment and internalised stigma**

***Introduction***
Peer support is commonly defined as 'offering and receiving help, based on a shared understanding, respect and mutual empowerment between people in similar situations'. Benefits of peer support have been established to include greater empowerment, confidence and self-esteem for those receiving the support as well as for the peer supporters themselves. While peer support values emphasise expertise by experience, there is still an acknowledged need for training. The first accredited course in the UK was developed by the Institute of Mental Health (IMH) in Nottingham.
***Methods***
As part of an evaluation of the training course, trainees have been invited to complete an evaluation pack pre- and post-training. A specific aim of this evaluation was to assess two potential outcomes of the peer support training course namely, changes to intrapersonal empowerment (hope, optimism and advocacy) and internalised stigma. Data from 116 trainees who consented to completing service evaluation will be presented.
***Results***
Findings from the evaluation indicated that the trainees who completed the course had an improvement in optimism, coping and advocacy and a reduction in the extent to which they endorsed stereotype of mental health problems.
***Discussion***
Date from the service evaluation provides information on the value of the IMH course in relation to empowerment and stigma, and reinforces qualitative feedback obtained from learners, who had described this training as ‘life changing’.

**Laurie Hare Duke**
**Towards a conceptual framework of belonging: a systematic review of measures**

***Introduction***
Social relationships show strong associations with various mental health problems and general well-being. Connectedness is a key process in personal recovery. Yet what exactly it means to be socially connected and whether people can experience connectedness in only one way or in many remains unclear. In particular it is uncertain whether there are any meaningful differences between feeling intimately attached and having a sense of belonging. If they are distinct then it is possible that they have different associations with mental health conditions and could represent different pathways to mental health recovery. They might also vary to some degree in their association with other notable elements of recovery such as having a sense of meaning in life and positive identities.

***Methods***
A systematic review of measures of belonging was conducted using several online databases. Study characteristics, psychometric properties and constructs operationalised were extracted.
***Results***
A conceptual framework of belonging was developed using narrative synthesis of pooled subscales from identified measures.
***Discussion***
It is possible that different individuals' journey to recovery may be related to distinct social motivations and goals. The results from this review will provide greater conceptual clarity on the concept of belonging and how it fits into a typology of social connectedness. This will allow further research into how different approaches could be adopted by individuals in their recovery journey and whether different strategies might need to be adopted by recovery-oriented mental health services.

**Parallel Session 4**
**Tuesday 19 September**
**3.30pm-5.00pm**

**Parallel Session 4.1**
**Theme: Re-situating recovery**
**Room: LT2**

**Graham Meadows**
**Principles Unite Local Services And Recovery (PULSAR): Introduction and overview**

***Introduction***

Mental health services in the Australian state of Victoria are working towards system-wide transformation through policy and legislation that promotes recovery oriented practice, supporting consumers to have greater choice and control in their lives. Such transformation will require new approaches, resources and proven processes including those which can foster cultural and attitudinal change in service staff. The Mental Illness Research Fund (MIRF) is a $10 million translational research program funded through 2013-2017 by the Victorian Department of Health; project selection criteria included alignment with Victorianpolicy statements including aspiration towards recovery orientation. This project, titled Principles Unite Local Services Assisting Recovery (PULSAR), is the largest single grant funded through the MIRF program. In this first of four linked papers, we will give an overview of the development of partnerships with 20 investigators and 10 organisations that led to the project, the overarching organisational structures, research methods, and translational processes.

***Methods***

This initial paper will introduce key concepts regarding stepped-wedge randomised trial designs then give an overview of PULSAR. In a mixed-methods study design conducted drawing on an explicit Knowledge translation model, PULSAR includes two separate stepped wedge studies, one in primary and one in secondary care with a range of accompanying qualitative data collection. These have varying design features regarding data collection points and stratification of randomisation. A series of recovery-related and clinical measures are collected in several specific time sequences through the four year project.

**Vrinda Edan**
**PULSAR Recovery orientated practice, the intervention**

***Introduction***

The PULSAR research project was inspired by the REFOCUS project conducted in London. Given the different legal considerations, mental health system, and organisational structures in Victoria some significant adaptions to the intervention was required. This paper will outline how the adaptions were identified, consulted on and integrated into a new training intervention across both Primary and Secondary Care.

***Methods***

A number of potential challenges of undertaking recovery oriented practice in Victoria were identified by the research investigators. Two focus groups were undertaken with staff from clinical and community services, and a series of interviews with GP's were conducted. A comprehensive literature review and examination of the REFOCUS trail intervention were central to the development of the PULSAR intervention.

***Results***

There are two separate interventions developed in both secondary and primary care. The first is the training component, delivered over 2 days to secondary care and 2 half day modules to primary care. Adaption to the secondary care training occurred between step one and step two following the analysis of training evaluations and interviews with the organisational trainers who delivered the training. The second intervention is monthly reflective spaces, identified as PALS, PULSAR Active learning sessions.

***Discussion***
Undertaking research into changing models of practice through training is complex and full of challenges. The lessons learnt during the implementation of the PULSAR intervention are identified and discussed.

**Penny Weller**
**Implementing PULSAR**

***Introduction***
PULSAR is being conducted in 19 secondary care sites and 18 primary care sites across a large area of metropolitan Melbourne. Given the complex demographics of the intervention sites, implementation was a vital part of PULSARs potential success. It has proven to be very important to be flexible and responsive to the needs of the participants while maintaining the fidelity to the original proposal and the REFOCUS intervention. Many adjustments have been made in this journey and this paper will explore how these have come about and the mechanisms employed to ensure fidelity.
***Methods***
Quantitative data assessing recovery is being collected in serial cross-sectional studies from in total over 1000 participants across multiple time points: typically baseline, end of year 1 and again at the end of year two with variation to this structure in the primary care setting giving greater emphasis on per-protocol collection and analysis. A subset of participants is also involved in up to two study interviews. The project also includes a series of qualitative studies with up to 60 participants exploring recovery oriented practice with both Consumers and Staff.
***Results***
The preliminary results from the data are explored in the fourth of these linked papers.
***Discussion***
The process of implementing a large, multi-institutional research project is multi-faceted and faces multiple challenges. Many of these challenges are specific to the area being studied and experienced in other research projects, such as GP engagement, and recruitment of consumers in mental health services. This paper will discuss how we planned to overcome these challenges, how the project adapted along the way and how the project management maintained fidelity with the original proposal.

**Lisa Brophy**
**PULSAR: Preliminary data**

***Introduction***
PULSAR is a large multi institutional and multi sector research program including data collected from over 1000 participants over multiple time periods.
***Methods***
The mixed methods design incorporates a two-step stepped-wedge cluster randomized controlled trial (cRCT) with nested qualitative and process evaluation sub-studies. Research participants are consumers aged 18-75 years who attended the service cluster within a previous three-month period either at baseline, 12 (step 1) or 24 months (step 2). In the two nested sub-studies, participation extends to cluster staff. At the time of writing data collection is nearly concluded.
***Results***
The preliminary results will be presented including the initial analyses with the primary outcome, Questionnaire about the Process of Recovery, which is collected from over 756 consumers (252 each at baseline, step 1, step 2). Secondary and other outcomes measuring well-being, service satisfaction and health economic impact are collected from a subset of approximately 252 consumers (63 at baseline; 126 at step 1; 63 at step 2) via interviews. Longitudinal data are also collected via interviews 12 months apart from a smaller number of consumers with a psychotic disorder diagnosis. cRCT data will be analysed using multilevel mixed-effects modelling to account for clustering and some repeated measures, supplemented by thematic analysis of qualitative interview data. The process evaluation will draw on a qualitative, quantitative and documentary data.

***Discussion***
The preliminary findings from the PULSAR study will be discussed along with implications for design of similar large scale translation research expertise.

**Vrinda Edan**
**Implementing Recovery Oriented Practice in Primary Care – a case study within PULSAR**

***Introduction***
The PULSAR qualitative study was designed so that early data collection would guide the nature and extent of subsequent data collection. During the PULSAR primary care intervention, GP Clinics identified varied experiences, barriers and enablers to implementing recovery oriented practice. To better understand these issues from multiple perspectives, the PI Prof Meadows, proposed that the qualitative study protocol be amended to add an in-depth case study at one of the PULSAR primary care sites. The purpose of this case study was to recruit and interview the multidisciplinary primary care staff team as well as consumers to explore recovery principles and practices in greater depth. This paper will describe this study and the outcomes from the analysis of the interviews with GP's, staff and consumers.

***Methods***
In-depth qualitative interview will be undertaken with GP's, Nurses and administrative staff who attended PULSAR training conducted on site and adapted for that service. Interviews are also planned with patients who attended the practice for care of their mental health concerns. These interviews will be analysed and themed.

***Results***
This important examination of recovery oriented practice in primary care is being undertaken as a student research project and results are expected to be completed in July 2017.

***Discussion***
The findings from this research will be discussed with implications for primary care practice.

**Parallel Session 4.2**
**Theme: Recovery for different groups**
**Room: LT5**

**Niamh Bergin**
**Does recovery CHIME with carers: A qualitative analysis of carers' experiences of personal recovery**

***Introduction***
Personal recovery for those with mental health difficulties is a construct gaining momentum within the research and policies of many Anglophone countries. Studies have begun to consider the place in recovery for those who care for a loved one with mental health difficulties. To date there has been very limited research exploring personal recovery for carers. This study explored family members' experiences of caring for a loved one with a mental health difficulty, and the relevance of the CHIME framework of personal recovery to these experiences.

***Methods***
Semi-structured interviews were conducted with five individuals who identified as carers. The interviews were transcribed and framework analysis, through the Connectedness, Hope and optimism, Identity, Meaning, and Empowerment (CHIME) framework, was used as a deductive analytical method. Inductive coding was also utilised to highlight any areas of difference emerging from the interviews.

***Results***
Recovery processes were broadly manifest across interviews, emerging as positive

recovery processes, as well as negative processes, where barriers to recovery were evident. Recovery processes were embedded within the caring journeys of participants. Participants highlighted the negative recovery processes, such as disempowerment by services, isolation, grief for their loved ones, and the limiting nature of caring on their own lives. Additionally, positive recovery processes including connectedness with other carers, becoming empowered in their identity as a carer, and continuing to support and encourage their loved ones' recovery, developed during the caring journey. Inductive analysis revealed four additional themes to be subsumed within the CHIME framework when considering carers' experiences of recovery.

***Discussion***

The insights into the intricacies of personal recovery for carers and recovery orientated caregiving has important ramifications for highlighting the place of carers within mental health systems, and developing the concept of personal recovery for carers.

**Qi Wang**

**The role of spirituality in the process of recovery from traumatic experiences – A Qualitative Research**

***Introduction***

Spirituality is an important aspect of human psychological well-being. Previous quantitative research has built models of the relationship between spirituality and recovery and transcendence from traumatic experience. However, the meaning of spirituality and spiritual experience among people who have experience traumatic events still needs more exploration.

***Method***

This study adopts the phenomenology research method to explore the meaning of spiritual experience in the recovery process of people who have experienced traumatic events. 8 People with and without religious believes are included in this research. Participants include people who have experience traumatic events in their daily life as well as spiritual experiences. Based on in-depth semi-structured interview, data was carefully collected and analysed.

***Results***

Although the causal relationship between spirituality and recovery from traumatic experience remains unknown, there is evidence shows that people benefit from spirituality growth in the process of recovery. People who are interviewed report that they would gain the experience and feelings of letting go and regain the meaning of life after pursuing spiritual development. Other themes of the spiritual experience including acceptance of self, forgiveness of self and seeing the nature and reality of life. Emotional and sensational themes including feeling of warm and light.

***Discussion***

After data analysis, this research shows that in the process of people recover from traumatic experience, spirituality plays an important role. Under extreme conditions, people tend to find spiritual peacefulness and spiritual development. This shed light in future program that to help people recover from traumatic experience, spirituality may be a topic that worth exploring.

**Susann Porter**

**Critical factors for the return-to-work process among individuals with depression: voices from two vocational approaches**

***Introduction***

Depression is among the largest single causes of disability worldwide with a negative impact on both daily life and work performance. Whilst depression is the primary cause of sick leave and unemployment today there is a lack of knowledge of how to best support individuals with depression in their return-to-work (RTW) process. The aims of this study were therefore to learn which factors can be of critical importance for the RTW process among people with depression, and to explore the impact of different vocational approaches on the service users' experience.

***Methods***
This qualitative study used in-depth interviews. Transcripts were analysed by means of a content analysis. Inclusion criteria were individuals with depression who had been participating in two diverse RTW interventions for 1 year; the Individual Enabling and Support (IES) approach in which the service user works closely with an Employment Specialist according to his or her preferences towards the goal of a real job directly, and Traditional Vocational Rehabilitation (TVR) in which service the support is provided stepwise by different welfare organisations. Here the first step regards reducing symptoms to increase work capacity and after that prevocational training.
***Results***
Three main themes emerged as critical factors for RTW; 1) experience of hope and power among service users, that 2) professionals' have positive attitudes, beliefs and behaviours about mental health problems, and that 3) RTW services employ a holistic perspective and integrate health and vocational service according to the individual needs.
***Discussion***
Providing individualised RTW support that is in line with the service users' own goals, needs and interests are in this study shown to be crucial for returning to work for individuals with depression.

**Lianne Powell**
**Reshaping lives: Supporting dual diagnosed service users to become their 'new me'**

***Introduction***
Kemple View is a 90-bedded hospital with low secure and locked rehabilitation wards. We specialise in the care and treatment of adult males with complex physical and mental health needs. Many of our service users are in various stages of recovery from substance misuse which has had a detrimental effect on their long-term recovery and wellbeing.
Historically, mental health and drug services have been provided independently resulting in service users (SU) being marginalised, passed between specialist services "from pillar to post" and in some cases disengaging from services altogether. This approach increases the vulnerability of SU with complex needs and is associated with "increased risk of violence, suicide and worse clinical and social outcomes" (Abou-Saleh, 2004).
***Methods***
In order to meet the needs of our dual diagnosed SU we have adopted an integrated approach to care, a model which ensures they receive concurrent treatment for mental illness and problematic drug and/or alcohol use from a single multidisciplinary team (MDT). Significant developments have taken place in terms of substance misuse provision and the specialist services (statutory and voluntary) we work with. We use evidence-based interventions to support care and treatment, including the introduction of a holistic substance specific assessment; development of pharmacological care pathways to support recovery; establishing strong links with our local recovery communities and our SU and staff are active members of various steering groups and recovery forums. Additionally, we support SU discharge planning and family / carer engagement.
***Results & Discussion***
This way of working has presented the MDT with a number of challenges in relation to ensuring that the need for security and risk management is balanced with the principles of least restrictive practice and the promotion of human rights including choice and respect. The presentation will highlight our hospital's developments in response to these challenges combining best practice in pharmacological, therapeutic and physical health care. Our service has had a positive impact on our dual diagnosed SU group offering them hope for the future, enhancing motivation and building confidence whilst offering a responsive approach to treatment. The treatment patients engage in pre-discharge and the links they make for support on discharge enables the SU to make informed choices about the future.

**Parallel Session 4.3**
**Theme: Re-situating recovery**
**Room: LT4**

**Giovanni Grassi**
**From secure forensic mental health services to community services: Utilizing - The Tree of Hope**

***Introduction***
The 'recovery process' is a personal journey of self-healing which involves providing a personal 'meaning' of one's mental illnesses. This paradigm encompasses the acknowledgment that the person's own experiences of mental health illness are unique to them. Successful recovery strategies are based on the recovery principles which enhance self-empowerment. Following consultation an updated model recovery resulted in the 'Tree of Hope' (figure 1) inclusive of 'Recovery Skills' element which required a new hierarchy of the recovery components (Ayres, Fegan, Noak, 2015; Repper and Perkins, 2012).

***Methods***
The updated model utilises people life experiences for personal empowerment enhancing the individual capacities to improve self-management through increasing abilities to manage psycho-social 'differences' by placing equal value on service users expertises to the knowledge of health carers professionals by encouraging an holistic psycho-social approach to recovery (figure 2). The psycho-educational model will allow participants to focus or refocus on the process of rebuilding own sense of self aided through the process of co-production and co-delivery (Sheppard, Boardman and Slade, 2008). (figure 2) Hope that you will achieve your goals in life Hope More control over your life and health Control To practice and develop your skills Opportunities Develop skills for your recovery Skills

***Results***
To date the data gathered through the administration of bespoke designed recovery focused questionnaire based on a Likert-type scale post attendance of psycho-educational recovery based courses delivered within the Recovery College supports the hypothesis. The categories in the 'feedback questionnaire' are linked to components within the 'Tree of Hope' model which are designed to incrementally map a person progress towards the aspirational stage of gaining and maintaining 'Hope' for the future (Perkins & Slade, 2012).

***Discussion***
Participating in the Recovery College activities strengthens a person sense of 'purpose' by increasing the sense of 'self' rather than one's mental illness. The Recovery College offers individuals, the skills required to challenge those stereotypes, enabling people to 'reframe' their mental health challenges through the development of self-management techniques which encompasses making the most of their personal 'talents', skills and life experiences to enhance their self- esteem which assist in the pursue their life goals.

**Stynke Castelein**
**Boost recovery: Implement resource groups in mental health care?!**

***Introduction***
Currently, in the Netherlands, most people with severe mental illness are treated by Flexible Assertive Community Treatment (F-ACT) teams, where various health care disciplines are integrated. However, there is little integration with other major influences in patients' lives, such as family members, friends and neighbours. In a resource group both the clients' personal environment and mental health care are represented. It is the client who determines what the overall recovery goals should be, but the group takes joint decisions about how to achieve them. Two independent studies are conducted in the Netherlands, which test the feasibility and possible effects of adding resource groups to F-ACT.

***Methods***
A pilot study investigates the feasibility and maps the difficulties of incorporating resource groups in F-ACT, and documents the experiences of both clients and clinicians involved in

the pilot. A second pilot study in the northern Netherlands also examines the cost effectiveness of resource groups when different health institutions drop their barriers and take a collaborative approach, with short communication lines between the different institutions: municipality, mental health and addiction care institutes. Both studies examine the feasibility of integrating resource groups with the care currently delivered by F-ACT-teams.

***Results***

These are two ongoing studies in the Netherlands. We expect to present preliminary experiences of patients and clinicians participating in these studies.

***Discussion***

It is expected that adding resource groups to F-ACT could result in more autonomy for the patients, more personalised care, greater effectiveness of treatment and support, and cost reductions in the long-term.

**Theodore Stickley**
**The art of recovery**

***Introduction***

In this presentation, we report on the findings of a study looking at the possible relationship between participation in arts activities and mental health recovery. We firstly use the CHIME framework (Leamy et al., 2011) for a rapid review process to identify the presence of recovery processes in the existing qualitative literature relating to arts and mental health. Having established the presence of recovery processes in the relevant literature, we then report on the secondary analysis of qualitative data produced from 38 interviews to identify recovery processes.

***Methods***

This is a deductive, secondary analysis of qualitative data seeking to identify recovery processes that were present in 38 transcripts of qualitative (narrative) research interviews where participants had not been specifically asked about the topic of recovery. The CHIME framework (Leamy et al., 2011) is used as an analytic tool to determine the incidence of recovery processes amongst participants.

***Results***

It is evident that all of the themes in the CHIME framework are present in the narratives. What is especially strong is the significance of support received from one's peers. The sense of community is deemed essential for recovery

***Discussion***

The findings from this study demonstrate the potential for participatory arts to promote mental health recovery. How such provision is initiated and sustained for the future is a challenge for policy-makers and service providers who are more used to providing services that are bio-medically driven and organised around government systems. New models need to be embraced and evaluated that provide more creative approaches to mental health care and that are not reliant upon statutory service provision and more community-orientated.

**Lucie Duncan**
**Challenging the care planning process and improving quality**

A joint project between KMPT, Christ Church University, Media Students, Carers, families and service users.

Aim- to create an Empathy raising video to educate NHS staff and students as to the issues around effective care planning for recovery from the point of view of the service user and their family and supporters.

Following focus group feedback a short film has been created with training questions written by service users and families in an attempt to encourage staff to think differently about how they plan for and run care planning meetings.

This film is shown to student clinicians, and to to qualified staff as part of a new and improved approach to care planning training. The new care plan training is non directive, but rather aims to draw on clinicians skill, raise empathy and insight, whilst encouraging

best clinical practice. It has been developed with a service user who has extensive experience in training, and his own expert knowledge from being a recent user of services. The film and new training has produced strong reactions that have led to great reflective learning for staff and students. Whilst a few staff have found the content overly challenging (no bad thing...), most have reported positively that it has changed the way they will work with people to create person centred recovery focused care plans in the future. One member of staff recently commented, " I just get it now....how to work alongside service users to plan their own recovery"
We are proud to have been able to co create a piece of powerful learning media in true collaboration with service users and carers/families. Roll out of the new care planning training continues, and we have plans to measures its impact on quality, and patient experience, as part of on going research. We would be happy to attend the conference to show the film, talk about the new training and to share our initial outcomes and feedback.

**Katarina Grim**

**Development and usability testing of a web-based decision support for users and health professionals in psychiatric services**

***Introduction***

Shared decision making (SDM) is considered a central component in a recovery-oriented practice. While decision aids are often regarded as an essential component for successfully implementing SDM they are still largely lacking within psychiatric services. The aim of this study was to utilize a participatory design in order to facilitate the development of a user-generated, web-based decision aid for individuals receiving psychiatric services. The results of this effort as well as the lessons learned during the developmental- and usability processes are reported.

***Methods***

The participatory design included 4 iterative cycles of development. Various qualitative methods for data collection were employed with potential end users who participated as informants in focus group interviews and individual interviews, and as usability and pilot testers.

***Results***

Interviewing and testing identified usability problems which led to refinements making the subsequent prototypes increasingly user friendly and relevant, and which. In each phase of the development process, feedback from potential end-users provided indispensable guidance in the formation of a decision aid for strengthening the position of users by building on an interactive web based environment.

***Discussion***

The decision aid which resulted from this process has the potential to strengthen service users' experience of self-efficacy and control as well as giving staff access to user knowledge and preferences. Studies employing participatory models focusing on usability have potential to significantly contribute to developing and implementing tools that reflect user perspectives.

**Parallel Session 4.4**
**Theme: Recovery for different groups**
**Room: LT1**

**Eva Brekke**

**Strengthening recovery orientation of services for persons experiencing co-occurring mental health and substance use conditions**

***Introduction***

Substance use and mental health disorders show a high degree of co-occurrence. Recovery has been suggested as an organising principle for the integration of mental health and addiction services, and recovery-oriented services are recommended through

Norwegian National guidelines. Still, services report difficulty in providing housing and participation in working life for this group of citizens, and persons with co-occurring conditions experience challenges in participating in their local communities. We need knowledge about how principles of recovery may be turned into practice in a Norwegian context, and how it is experienced by service users, family and staff. The aim of this project is to explore and describe how principles of recovery oriented practice can be applied to increase the safety, participation and inclusion of persons with co-occurring conditions in a Norwegian rural community.

***Methods***

The context is a local authority area in Eastern Norway which consists of agricultural areas, forested areas, and two community centres (<6500 inhabitants). Within a collaborative approach, data material has been gathered from focus group interviews with staff of the municipal mental health and addictions team, and individual interviews with service users and family members. Services are committed to applying the knowledge into practice development. A competence group consisting of persons with experience of co-occurring conditions, family members and staff assists the researchers throughout the process.

***Results***

Results are pending and will be presented at the conference.

**Alie Weerman**

**Disclosure of personal experiences of social work professionals**

***Introduction***

In the Netherlands, a major transformation of the social care system is taking place. There are two major changes. The one is the shift from a centralized organised service system towards a local community based system. The second is the growing emphasis on informal care and support, in which self-reliance and reliance on natural supports is the focus. This has given a boost to user involvement and recovery oriented practices. As a result, there is large attention for experiential knowledge and peer support. In the light of these developments more and more peer experts are working in mental health care, addiction and other services. They work side by side with other professionals. A substantial part of these professionals has personal experiences with (mental) health services themselves. Recent research shows the importance of revealing and disclosure of the personal experiences of this group ((Weerman, 2016). But little is known about how to disclose and use this experiential knowledge in an appropriate way. Therefore, two universities in the Netherlands started a research project, involving professionals of four service providers.

***Methods***

We use practice and arts-based action research methodology. This will result in new findings for education purposes and simultaneously will improve the current practice. The research team aims to integrate both practice and research by working with responsive methods, such as focus groups and interviews (Stake, 1975; Lincoln & Guba, 1985). Promoting the engagement of experiential knowledge as an essential source is linked to an emancipatory type of research and matches the values of modern Social Work as mentioned by Sarah Banks (2012).

***Results***

Apart from the innovation process in four organizations, a number of products will be developed such as tutorials for education purposes, new insights about the position of the new Social Workers in relation to other professions and inspiring good practices.

***Discussion***

Interesting themes we would like to discuss with the participants include;

1. The relation of the recovery model and the use of user's expertise;
2. Developing new standards and roles for the involved social workers;
3. The hoped, expected and experienced outcomes of working with experiential knowledge in a professional setting;
4. Do participants recognize the mentioned developments from the Netherlands and/or

what differences in other countries do we see?
5. What way can we profit from experiential knowledge in Social Work education? Should we influence the educational climate more thoroughly? What is needed to promote 'self-disclosure'?

This contribution will be led and co-created by both researchers and professionals of the research project. (Names of co-presenters are subject to change).

**Phil Morgan**

**The impact of co-produced mental health training for paramedics**

***Introduction***

The focus of this work was to explore the impact of a week of mental health training co-created and co-delivered by Peer Specialists, Mental Health Professionals, Paramedics and Paramedic Lecturers and Students. To explore if it could change the approach and build the confidence of paramedic students to supporting people with mental health problems. Traditionally paramedic students had a placement where they sat with a mental health team for a week, however people's experience varied and did not appear to have much value for some. By co-creating a programme with people who had access paramedic and ambulance services it was hypothesised that the paramedic students would get a more comprehensive understanding of their role, what they can offer people and have an increased understanding of a range of mental health experiences.

***Methods***

This was a local service evaluation based on survey results and feedback forms.

***Results***

Changed people's attitudes to mental health, increased confidence in offering people with mental health problems support and helped people identify the importance of looking after their own mental health. In additional there was some feedback relating to their own resilience increasing and group cohesion has a whole. Also a number of people an increased understanding of the impact they have on people's lives when perhaps they feel they have not done anything.

***Discussion***

This week of mental health training was innovative approach involving the perspectives of a whole range of people to create a shared learning environment. The discussion fill focus on how the course was co-developed and co-run. The challenges and opportunities this provided and how this is going to be taken forward this year. There will also be a discussion on the next steps in regards to evaluation.

**Louise Canacott**

**Recovery for women with borderline personality disorder in secure services**

***Introduction***

Until recently there has been a paucity of research relating to recovery for people with personality disorder. The development of psychological interventions demonstrating effectiveness in reducing the clinical symptomology associated with personality disorder, the possibility of clinical recovery gained empirical support. However, psychosocial recovery for people with personality disorder has been shown to be a more enduring process, suggesting that remission of clinical symptoms does not equal recovery. Personal recovery which may comprise clinical and psychosocial recovery has been under-researched within this population and perhaps most salient, within specialist services for people with personality disorder. Women with personality disorder comprise 16% of the medium-secure mental health population. As women they are likely to have experienced social disadvantage, abuse and trauma. They face the dual stigma of living as women with mental illness and also their identity as offenders. The complexity of the needs of this client group and the enduring nature of their difficulties may render the recovery process difficult to envisage. With recovery-oriented practice becoming a performance marker for many mental health providers, understanding how the topic is viewed by those in receipt of services is essential for ensuring the integrity of the recovery approach is maintained and that service-users voices are heard. This research aims to

generate a theoretical understanding of the meaning of recovery for women with borderline personality disorder receiving treatment in medium- and low-secure services.

***Methods***

The research will be an exploratory, qualitative study based on individual interviews with service-users. Up to 15 women will be recruited from medium- and low-secure forensic services. Data will be analysed using grounded theory methodology.

***Results***

Results will be presented from the ongoing research project. Data will be analysed to develop an inductive theoretical understanding of recovery from the perspectives of women with personality disorder in secure services.

**Leila Persaud**

**Factors which contribute to a successful recovery programme: Two case studies**

What makes a successful Recovery Programme? Are there definable factors that can help us assess whether a programme is likely to be successful? These and other relevant questions will be explored using practical examples based on two case studies from the homelessness sector.

**Parallel Session 4.5**
**Theme: Allocating resources**
**Room: LT6**

**Pooja Pillai**

**'Pictures make it easy' – co-development of a visual tool for recovery in North India using participatory action research**

***Introduction***

There is an emerging call for increased community voice in global mental health, to balance bio-medical priorities that have dominated. Recovery approaches demand tools that reflect local context and priorities. Northern India, with a Hindi speaking population of 600 million and limited services accessible to people with psycho-social disability (PPSD) has few models of community-based mental health and to our knowledge, no accounts of 'recovery' approaches co-produced with service users. This study aimed to strengthen locally relevant knowledge and skills in mental health recovery among PPSD, carers, community leaders, mental health practitioners and policy makers in communities in Uttarakhand through the co-production of a socio-centric visual tool for recovery.

***Methods***

This project is set in Burans, a partnership community mental health project of the Emmanuel Hospital Association, in rural and semi-urban communities in Uttarakhand state, India. A participatory action research framework was used to develop the recovery tool, working in partnership with community experts by experience (EBE) in psycho-social disability. We used participatory methods including transect walks and symbols that represented users diverse trajectories to mental well-being, focus group discussions and ethnographic methods to generate key domains of recovery.

***Results***

A visual tool representing key domains of recovery for mentally distressed families was developed to support community-based recovery approaches. The tool and the process of development will be presented.

***Discussion***

Engaged participation of family members/ carers in this tool was identified by all participants as critical in this South Asian context where most people with mental distress live with family members. Key approaches included co-production and participatory and visual methods which maximised involvement of EBE who had little formal education and engagement with local determinants of recovery such as caste, economic status, gender and explanatory models of mental distress.

**Simon Riches**
**Social performance and paranoid ideation: using virtual reality to resituate recovery-focused interventions**

***Introduction***
Social relationships are an important factor in promoting recovery. They are significantly related to health and wellbeing. Difficulties with social performance overlap significantly with paranoid ideation. Virtual reality (VR) technology offers a promising way to resituate and develop recovery-focused interventions because VR can be tailored to individuals and enable psychological assessment in ecologically valid environments. This study, in two phases, aimed to recruit a general population sample; test for paranoid ideation and its correlates in components of social performance and mood; then piloted a new VR social scenario in non-clinical participants with high and low paranoid ideation; and to investigate whether these components of social performance and mood were associated with increased paranoid ideation in a VR social scenario.

***Methods***
In Phase 1, a general population online survey (N=609) investigated how trait paranoia related to fear of negative evaluation, interpersonal sensitivity, social avoidance and distress, and mood. In Phase 2, two groups were formed from phase 1: participants who scored high and low in trait paranoia (N=89) entered a virtual social scenario to evaluate the acceptability of the task and the relationship between paranoid ideation and social performance.

***Results***
As hypothesised, in Phase 1, trait paranoia was associated with components of social performance and mood; in Phase 2, participants found the VR environment acceptable and immersive; exposure to the VR environment elicited a range of cognitive, affective, and behavioural components of social performance; and high trait paranoia participants reported higher state paranoia and greater negative components of social performance.

***Discussion***
This study demonstrates that the VR social scenario has assessment and treatment applications for people with psychosis, who can experience paranoid ideation in social situations. Such applications have the potential to be an important therapeutic tool and significant addition to recovery-focused interventions.

**James Wooldridge**
**Recovery Devon Development Fund**

***Introduction***
The Recovery Devon Development Fund was created to support individuals and organisations across Devon with innovative ideas for recovery-focused projects.

***Methods***
Small grants of up to £750 were awarded to eight projects in 2016 ranging from drama in schools, massage therapy research, mental health first aid training for barbers, suicide bereavement support packs, 'Happy to Share' cards to combat loneliness and rural arts workshops. The application process was kept deliberately simple and accessible and people with lived experience of mental health challenges were encouraged to apply.

***Results***
Not all projects completed their work but several gained regional and national media attention. The Torbay Lion's Barbers Collective were featured in the local press and were invited to talk on BBC's Breakfast programme. 'Happy to Share' cards which were made available in cafes across Devon including several national chains, were discussed on Radio Devon and many requests for cards have been received from other regions. The massage therapy research results were used to help justify the continuation of 'pamper sessions' at the mental health wards in North Devon. The eight project leads came together for a celebration event on World Mental Health Day where each presented their outcomes. A local drama group created visual and interactive sketches from the projects and a video was produced with support and funding from The Big Lottery.

***Discussion***
The wonderful outcomes that can arise when relatively small amounts of money are put in the hands of individuals who have great ideas and the energy to make them happen.

**Ian Henwood**
**The benefits of co-production**

***Introduction***
Starting from scratch, and in just under 2 years, the Lived Experience Advisory Panel (LEAP) has recruited 70 members including people with lived experience, carers and NHS staff. It is part of Recovery Devon, a community interest company with many years experience of shaping mental health services.

***Methods***
LEAP is tasked to weave the voice of lived experience like a golden thread through the fabric of Devon Partnership NHS Trust. It builds on my personal experience of being a carer for over 10 years. We work alongside staff with one common aim to improve services by the method of co-production.

***Results***
The benefits from this approach are great - from developing services that are recovery focused and personalised, to 'LEAPsters' benefiting from their involvement experience as part of their recovery journey.

**Parallel Session 5**
**Wednesday 20 September**
**10.30am-12.00noon**

**Parallel Session 5.1**
**Theme: Recovery for different groups**
**Room: LT2**

**Joanna Fox**
**Reflections on developing a blended learning recovery education programme for mental health carers**

***Introduction***
Mental health caring can have a significant impact on carers' well-being and life opportunities. Family carers are a neglected group that has hitherto been excluded from involvement in and development of the recovery concept (Fox, 2013). There are limited interventions for carers to support them in their caring role and enable them to care in the most effective ways (Yesufu-Udechuku et al, 2015).

***Methods***
Using a participatory approach, a steering group built on an already developed face-to-face education recovery programme for carers (Fox, 2013) to design a blended learning course that embraced both eLearning and face-to-face learning. This group met regularly for a year and had membership representing expertise from different stakeholders. Expertise-by-caring and expertise-by-experience were central to the development of the programme.

***Results***
This course has been developed and incorporates five sessions: three face-to-face and two online. It emphasises the provision of information about recovery through experiential learning underlining the importance of lived experience. The programme is facilitated by a service user (who is also a social worker and academic) and a carer trainer. It is underpinned by an approach that encourages carers to support their family member with hope and optimism, leading them both to reflect on their simultaneous but separate experiences of recovery.

***Discussion***
Blended learning has developed an increasing evidence base for its effectiveness in health and social care education (Young and Randall, 2014). Despite this, the utilisation of online packages of care is relatively recent in mental health caring (Lobban et al, 2013). The framework balances an approach that enables the carers to experience peer support as they share their joys and stresses with the group and allows learning to be convenient and time-efficient for busy family carers of people with mental ill-health. Planning is currently ongoing to deliver the programme in partnership with the local Recovery College.

**Rhiannon Foster**
**Peer support, professionalisation and authenticity in mental health services: A Foucauldian perspective**

***Introduction***
Peer support in mental health developed as a reaction to negative coercive treatment of patients and contributed to a shift in language from talking about mental disorder (focus on symptoms and disease) to Recovery (strengths and opportunities). Peer workers (PW) – people with personal experiences of mental health problems employed to use those experiences in supporting others – are being introduced into formal mental health services in a number of countries. This professionalisation brings the possibility of new ways of working, but may also create sites of tension between these emerging experiential understandings of mental health and more established mental health practices. Aims: How are discourses of peer support enacted in the context of academic peer reviewed publications, as well as both mainstream mental health services and peer-led services? Does the emerging professionalisation of peer support roles mitigate the emergence of a

genuine peer-led, experiential discourse of peer support?

***Methods***

In the first stage of the research I will be carrying out a discourse analysis of academic peer-reviewed texts of one-to-one peers support in mental health to explore how they may (re)produce professionalised accounts of peer support. In a second stage I will interview service users, peer workers and a range of different stakeholders about their experiences of giving and/or receiving peer support, to explore how discourses of peer support are enacted in different contexts.

***Results***

A discussion of the results to date will be presented with conclusions.

**Stephanie Barker**

**Peer-support and helping the homeless: A qualitative study on critical elements and experiences of peer-supporters**

***Introduction***

Homelessness services are increasingly incorporating peers into their recovery models, to engage with entrenched rough sleepers, increasing access to health care, facilitate relationships among primary carers, and reduce health barriers. Research lacks in its exploration of peer-support and homelessness. The current study aims to ascertain participants' experiences of providing and/or receiving peer-support and the critical elements involved in supporting those who are homeless.

***Methods***

A qualitative study was conducted. Participants from four different homeless charities in England engaged in semi-structured, one-to-one, audio recorded interviews. Questions focused on providing and/or receiving support and what participants felt were critical factors to peer-support success. Thematic analysis was utilised to generate themes and patterns from interviews. Participants were paid a £5 voucher for their time.

***Results***

Twenty-three males and 6 females (Mean age = 46) participated in this study. All participants had experience with homelessness and peer-support. Mean time spent as a peer-supporter was 1.38 years (SD = 1.42, Range = 3 months to 5 years). Twenty-one participants reported previous experiences of rough sleeping. The average time spent homeless was 4.7 years, ranging from one month to 20 years (SD = 4.91). Twelve participants reported addiction issues. All 12 of these participants reported being in recovery; the minimum time in recovery stated was 18 months (M = 9.5, SD = 9.4). Participants defined peer-support as an experience-based relationship, built upon mutual understanding, empathy, and support. Analysis generated 6 themes that describe the critical elements of peer-support. Peers benefit from helping; undergoing transformative identity developments where peers re-story their experiences by verbalising them to clients.

***Discussion***

Employing a peer-support model enables peers to escape homelessness by encouraging identity development and acquire transferrable skills to re-enter the workforce. Limitations of the research and future directions will be discussed.

**Donal O'Keeffe**

**A meta-synthesis of service users' perceptions of the meaning of and influences on recovery in 'psychotic illness': Implications for research and practice.**

***Introduction***

The aim of this review was to conduct a meta-synthesis of qualitative studies examining the meaning of recovery and influences on recovery from the perspective of people diagnosed with 'psychotic illness'. Due to the substantive difference between the experience of 'psychotic illness' and other types of 'mental illness' and the absence of a systematic review or meta-synthesis of this nature in the literature, there is a clear rationale for examining recovery in psychosis as a separate entity if a recovery orientated approach to care is to be realised.

***Methods***

A systematic review and meta-synthesis were undertaken to identify and synthesise relevant published studies. Databases PubMed, PsycINFO, CINAHL Plus, Psychology and Behavioral Sciences Collection, and Web of Science were searched using control language search terms and free-text search strings. Reference lists of included articles were also hand searched. Results: 12 articles reporting on nine discrete studies were included. The resulting framework of recovery in 'psychotic illness' comprises (i) six major themes: 'Societal Value', 'Independence', 'Meaning in Life', 'Freedom from the Mental Health System', 'Optimism and Motivation'; and 'Safety and Peace' and (ii) factors that support and hinder recovery which operate on five inter-connected levels: individual; family; friendship/peer/other support; mental health system; and societal. Discussion: This meta-synthesis sheds light on what is unique about recovery in 'psychotic illness'. The conceptual framework developed can inform the scientific agenda for recovery in psychosis, future policy development, and the configuration of services. It may also enable innovation within services seeking to support people's recovery.

**Joy Rooney**

**Patients' views of intentional mental health peer support**

***Introduction***

Views of receivers of intentional mental health peer support are a good way to gauge the effectiveness of peers; few are available in the literature. This presentation aims to explore patients' experiences expanding on earlier work (Rooney, Miles and Barker 2016).

***Methods***

Patients participated in in-depth semi-structured recorded interviews adapted from McLean et al (2009) conducted by a third year undergraduate BSc psychology student from the University of Worcester. Interviews were transcribed verbatim and the authors read and reread the scripts and agreed 58 excepts. These were analysed into overarching-theme, themes and sub-themes. Anonymised quotes, agreed with the interviewees, illuminated these themes.

Anonymous patient feedback forms also captured views on discharge which contained questioning around helpfulness of the peer support service, listening and helping skills and valuing patients' wellbeing and recovery by the peers and whether patients will recommend the peer service to family and friends.

***Results***

The overarching theme was that of communication with patients. Six themes and up to seven sub-themes were identified as being person-centeredness, practical support, building connects, emotional support, modelling hope and recovery interventions. These will be presented as a thematic map with supporting quotes.

Patient feedback forms demonstrated a very positive response in all regards; these will be given with examples of quotes.

***Discussion***

Opinions and perceptions of groups of people are well served by using qualitative methodology. Overall the quantitative and qualitative literature demonstrates that peer support is beneficial. Here qualitative methodology is useful to define themes which can then be used to generate hypotheses to test in larger scale studies. Patients do indeed value the input of peers in this setting.

**Parallel Session 5.2**
**Theme: Recovery for different groups**
**Room: LT5**

**Jojanneke Bruins**
**VOICE: Valuing opinions in communication experiences in severe mental illness**

***Introduction***
The therapeutic alliance (TA) is an important a specific factor in recovery and treatment outcome in people with a severe mental illness. Many sources emphasise that investing in a good TA is essential in treating and supporting people with a severe mental illness. However, most studies have focused on the effects of a good TA on treatment, but (longitudinal) research on how to build and maintain a good TA is lacking. The VOICE study aims to identify factors that contribute to the realisation and continuation of a good TA.

***Methods***
Firstly, possible factors influencing the TA are identified through focus groups (n=64) and in-depth interviews (n=15) with patients, peer support workers and other mental health care professionals. Secondly, these identified factors and the quality of the TA are monitored for 12 months in a longitudinal study. We aim to include n=150 sets of a patient with severe mental illness, their case manager and their primary treating mental health care professional. Assessments are conducted at baseline, 3, 6 and 12 months and experience sampling methods are used to evaluate each therapy session.

***Results***
The study will commence in the summer of 2017.

***Discussion***
The goal of this study is to provide mental health care workers with concrete tools they can use to build and maintain a good TA with their patients. We aim therefore to incorporate the results of this study in treatment guidelines and health care standards.

**Christine Wilson**
**Let's Talk! about psychological therapies in Wales**

***Background***
Let's Talk! about Psychological Therapies is a Welsh based, Hafal initiative funded for three years by the Big Lottery People and Places Programme. Hafal (meaning 'equal'), is the principal third sector organisation in Wales working for, and managed by, people with serious mental illness and their carers.

***Let's Talk!***
Aim: To promote access to evidence based psychological therapies for people within Wales with a serious mental illness. The project has 5 objectivise, objective 2 is the subject of this current research:
2- an 'Advocacy' training programme designed to up skill Hafal staff and people with a lived experience of mental illness, and their carers. The training aims to support people in Wales to be able to access psychological therapies more swiftly;

***Methods***
Using a qualitative design, two consultation events were held to obtain participant views on the content of the Advocacy Training. 80 participants with a lived experience of mental illness and carers, aged between 23-75 years, residing in Wales, took part.

***Results***
Data was merged and themed. Three main themes emerged from the Coding frame, The increasing access to evidence-based psychological therapies 'Advocacy' training should:
1- provide participants with an understanding of NICE guidance for each of the different psychological conditions.
2- provide participants with the necessary skills to support them in negotiations with their care provider (GP, CPN etc) whilst trying to access 'dual treatment' e.g. medication and 'talking therapies'.
3- provide participants with information about accessing evidence based 'talking

therapies' from the private and voluntary sectors in particular.
Findings will be taken forward and used the 'Advocacy' Training programme which will be piloted in 2017 with ongoing evaluation and implementation.

**Fiona Ng**
**What goals do individuals with Borderline Personality Disorder have for treatment and recovery?**

***Background***
Recovery from Borderline Personality Disorder (BPD) has been described as a process involving both clinical and personal recovery components. Personal recovery from BPD has been seldom investigated. The majority of studies pre-determine outcome variables using set clinical questionnaires and interviews. This presentation will present new data on what consumers with BPD want when asked to freely self-generate recovery goals.
***Method***
The self-generated treatment goals of people seeking treatment for BPD were collected. Responses were independently content analysed into themes by two raters to determine the domains of recovery people want from treatment.
***Results***
People seeking treatment for BPD (N=102) self-generated 464 goals. Four main goal types emerged in the content analysis - having a greater sense of self; better interpersonal relationships; improved wellbeing; and reducing symptoms. Although the reduction of clinical symptoms was the most commonly reported goal, more than 85% of people reported wanting better psychosocial functioning including improvements in relationships and self-understanding.
***Discussion***
Self-generated goals include a broader set of outcomes than those typically measured in current research trials. People seeking treatment not only want to reduce their symptoms but also want help to understand themselves, improve their relationships with others, and have better vocational and employment prospects. The presentation will discuss the implication of these findings for research and clinical practice.

**Diana Byrne (Cunningham)**
**From ward to Board: triumph over tragedy**

I was sectioned 36 years ago. I was put in an asylum for two and a half years. I then went on to become a revolving door patient, for the next 30 years. My psychiatrist told me I would never hold down a job that involved thinking. I wish he could see me now. My recovery journey is an inspiring one triumphing over trauma and tragedy with two suicides in my family, and my own attempts. I am now a NHS Governor, I teach at Brighton and Sussex Universities and Clinical Psychologists at Salomons. I am also a Peer Support Trainer, and a Recovery College Trainer. I have recently returned from Sri Lanka working as a volunteer, developing Recovery College and Peer Support. On my own it was an amazing experience, and I achieved a lot. Developing my own Self Awareness and coping strategies facing daily challenges, the thing i learnt about my own recovery was that "I could cope with whatever challenges life threw at me". I am an excellent public speaker, engaging and inspiring I can guarantee my presentation will be one no one will forget.

**Parallel Session 5.3**
**Theme: Recovery for different groups**
**Room: LT4**

**Katja Milner**
**The role of spirituality in mental health and recovery**

***Introduction***
There has been increasing awareness of the importance of spirituality and religion to mental health issues in public, research and health care discourses. Systematic reviews

have identified beneficial effects of spirituality/religion on health and mental health with some challenging effects and associations. Consistent themes to emerge from the literature demonstrate that people using mental health services would like to have their spiritual needs addressed, however a 'religiosity gap' between staff and service users has been highlighted in which spiritual factors are often undervalued by professionals. Developing understanding of the role of spirituality in mental health and recovery has the potential to contribute to a deeper vision of recovery long endorsed by many people who experience mental health difficulties.

***Methods***

A summary of findings of a literature review will be reported highlighting the role of spirituality in mental health and recovery which include empirical findings, personal lived experience and broader literature and theories which can bring light to the topic.

***Results***

Research has demonstrated spirituality to be helpful for understanding mental health recovery as it can facilitate understanding, promote the values of recovery such as hope and empowerment, can reduce stigma and can facilitate self-awareness and wellbeing. A psycho-spiritual perspective could help further develop understanding of mental health recovery which includes and integrates the spiritual dimension.

***Discussion***

Much of the existing research literature exploring spirituality and mental health and recovery focuses on clinical outcomes or the perspectives of professionals rather than people's personal lived experiences. There is a need in future research to focus on the narratives of people with experience of spirituality and mental distress and recovery to help address the 'religiosity gap' identified in the literature in the understanding and value of spirituality between service users and professionals.

**Chiara Samele**

**Supporting forensic mental health service users into employment and vocational activities: A pilot scheme**

***Introduction***

Few employment programmes exist to support forensic service users with severe mental health problems and a criminal history. Little is known about how best to achieve this. The Employment and Social Inclusion Project (ESIP) was developed and piloted to support forensic service users into employment and vocational activities. This pilot service evaluation aimed to assess the number of service users who secured employment/vocational activities and explored services users' and staff experiences/ perspectives.

***Methods***

Quantitative data were collected to record the characteristics of participating service users and how many secured employment and engaged in vocational activities. Eighteen qualitative interviews were conducted with service users and staff.

***Results***

Fifty-seven service users engaged with the project, most were men (93.0%) and previously employed (82.5%). Four service users (7.0%) secured paid competitive employment. Eight (14.0%) gained other paid employment. Tailored one-to-one support to increase skills and build confidence was an important feature of the project. Creation of a painting and decorating programme offered training and paid/flexible work.

***Discussion***

This exploratory project achieved some success in assisting forensic service users into paid employment. Further research to identify what works well for this important group will be of great value.

**Andrew Shepherd**

**Recovery within prison as a process of identity construction**

***Introduction***

Prisons represent sites of intense mental suffering for a considerable number of people.

Mental Health Professionals working within such institutions are charged with supporting individuals as they address this distress. Understanding the workability of recovery orientated frameworks within such settings represents a complex challenge however, since the requirements of prisons as institutions can be seen as being largely opposed to many of the key factors identified within the experience of recovery in the wider literature. The current study therefore aims to better map the 'lived experience' of recovery as described by those accessing care and working within prison environments.

***Methods***

Individual interviews were conducted with individuals receiving a 'personality disorder' diagnosis and accessing mental health care within a prison setting. Focus group interviews were arranged with professionals within these same institutions. A qualitative thematic approach to analysis was adopted.

***Results***

Recovery was identified as a process of 'identity work' wherein individuals endeavoured to make sense of their personal experience in relation to concepts such as 'offending behaviour' and 'mental disorder.' This process was highlighted as being complicated within prison owing to the estrangement of the individual from their home social networks and complex manifestations of stigma relating to the individual as a 'mentally disordered offender.' Professionals identified the support of personal recovery as a form of 'sentimental labour' and described specific complications relating to conceptualisations of mental disorder and the complexities of multi-agency working within prison settings.

***Discussion***

The conceptualisation and enactment of 'recovery' within such institutions is a complex process encompassing the interaction of various agents and their competing understandings. Individuals seeking help and professionals offering support within such settings both undergo a process of work for which considerable support is required to allow its continuation in a 'safe and secure' manner.

**Lorna Loftus**

**'Steps in Wellness' - A pilot group programme in a Liaison Psychiatry Service**

***Introduction***

This future orientated & recovery centred group programme ran over 5 weeks in November – December 2016 with 6 participants from the Liaison Psychiatry OPD, all who attended Beaumont Hospital reporting medical symptoms prior to being referred to Psychiatry.

***Methods***

Qualitative Questionnaire using open ended questions given to participants at end of five weeks. Qualitative feedback was also sought from the Consultant Psychiatrists the service users were attending.

***Results***

Four participants completed the programme. Feedback from the group evaluation was very positive. Participants reported finding the weekly 'homework' of benefit in exploring personal perspectives and goal setting and noted the experience of discovering in a group setting central to positive experiences. This was an interesting finding as all had voiced reservations regarding the group modality prior to their participation. A further strong theme which emerged was that the future & wellness orientated focus of the group was reported to be very helpful in getting people thinking about change despite participants initial challenges in shifting from 'illness talk.' Psychiatrists reported their surprise in the level of engagement achieved given the significant challenges for many of those attending in considering a broader dimension to their clinical presentations.

***Discussion***

The group aim was to engage those for whom support from health services had become a primary focus in an attempt to mobilise their personal capacities in living well despite physical their physical health challenges. The group endeavoured to promote self-efficacy in achieving and maintaining recovery & wellbeing. The Programme was developed to meet the needs of those who were not currently able to benefit from successfully

established hospital programmes. The 5 key areas explored throughout the group were as follows: 'What is Wellness?', 'Enhancing Hope', 'Locating Support,' 'My Voice' & 'Knowledge.' Participants were prompted to evaluate their current position in relation to each of these dimensions and were supported by the group in setting goals to develop a pathway for each with the aim of increasing their level of wellbeing.

**Parallel Session 5.4**
**Theme: Recovery for different groups**
**Room: LT1**

**Michael Schwartz**
**Celebration Recovery: A decade of past celebrations in the US and a new global celebration coming in 2020 in France!**

***Introduction***
"Celebration Recovery" – Multiple gala public events celebrating recovery from psychiatric conditions; busting stigma, and promoting hope and optimism – were planned at diverse sites across the US from 1999 through 2008.

***Methods***
Narrative

***Results***
Public events celebrating recovery from psychiatric disorders can have enormous impact personally, socially and politically.
Discussion: In 1999, a small US Foundation – the Irwin Foundation – decided to host celebratory events across the US celebrating recovery from psychiatric disorders. The project had multiple goals:
1. Busting stigma – recovery from physical illnesses – such as heart attacks, are always celebrated. Those who recover from psychiatric disorders often hide their experiences due to stigma – advancing the myth that no one recovers. Celebration Recovery was intended to end this myth. We would spread the word that individuals with mental illness can and do recover.
2. Celebrating Recovery. Events were festive – as can be seen from the website www.irwinfoundation.org/celebration/cr_events.php . We were "Celebrating success and creating hope!"
3. "Celebration Recoveries" brought together individuals in recovery, their friends and families, professionals, and others who work with them, and the broader, caring community in a festive, gala event with inspirational talks, music, art, fellowship, and educational presentations. Our large public parties mixed doctors and patients – and who could tell the two groups apart?
Initially, organized psychiatry warned us of dangers re the project – we would be promoting "boundary violations." A few years later, consequent to great success, parties were held conjoined with national American Psychiatric Association meetings! Between 2001 and 2008, 23 parties were held all over the United States. The project concluded – successfully - when US President George Bush officially called for Peer Support as a needed consumer-based mental health service.
Going forward, there will be a large meeting in Marseilles in 2020 focused upon "Hope and Recovery" – at the heart of the meeting we plan a large, global Celebration Recovery. Join us!

**Ella Hancock-Johnson**
**Paid formal lived experience workers (LEWs) within a secure mental health service - their experiences**

***Introduction***
Service user involvement has been applied within various settings, including the Criminal Justice System (Clinks, 2011) and mental health services (Millar et al., 2016). Formal

roles have been created for people with lived experience of mental health issues and mental health services to be involved in the delivery of services. These roles have been defined as a lived experience worker (LEW): a person who is employed in a role that requires them to identify as being, or having been a mental health service user (MHCSA, 2016). The purpose of this presentation is to report the experience and impact of paid staff who are employed to use their lived experience of mental health issues and service use within a secure mental health provider.

***Methods***

A qualitative approach was employed, using semi-structured interviews and thematic analysis.

***Results***

Results from this study suggest that employing lived experience workers in secure mental health settings is valuable to non-peer staff, service-users, the employing organisation and lived experience workers themselves. Findings emphasised the importance of support for lived experience workers to enable them to fulfil their role and maintain wellbeing, and the need to consider lived experience workers career progression within and beyond the role.

***Discussion***

There is evidence to support employing lived experience workers in secure mental health settings and there is a requirement for further understanding of LEWs working in this environment. Specific recommendations include: the need for training for non-peer staff about the role of lived experience workers, specific lived experience workers role training, and regular supervision and mental health support for lived experience workers.

**Bridey Rudd**

**Recovery and alcohol related brain damage**

***Introduction***

Milestone is an alcohol-free step-down unit designed to provide short-term care for vulnerable adults living with a diagnosis of Alcohol Related Brain Damage (ARBD). It aims to provide an environment conducive to rehabilitation and recovery by adopting a personal recovery approach based on the HOPE framework of support developed by mental health charity Penumbra, alongside a neuro rehabilitation programme using evidence-based techniques. This project evaluates the impact of the service on the progress towards recovery made by people using Milestone, using measures of personal and cognitive recovery, including the ACE III cognitive assessment tool, which although recommended by NICE guidelines, has yet to be validated for use within the ARBD population.

***Methods***

During routine practice, residents completed three measures of functional and personal recovery. I.ROC was used shortly after admission (and quarterly or before discharge thereafter); the ACE III was used after 2 weeks and every 4 weeks thereafter, and the RBANS was completed after approximately 8 weeks.

***Results***

Results show significant improvements in both cognitive and personal recovery between admission and discharge on all three measures. Cognitive assessment scores are correlated with length of time in service, with those scoring lowest on cognitive assessments at baseline staying the longest in service. ACE III and RBANS results were also highly correlated.

***Discussion***

Correlation between RBANS and ACE III support the validation of ACE III as a cognitive assessment for use within an ARBD population, whilst increases on all three measures reflect significant gains in personal and cognitive recovery during time in the service. Results of this study will be discussed in relation to the application of a recovery model to a new population; people living with alcohol related brain damage. Discussion will also focus on the relationship between personal and cognitive recovery, and the implications for practice.

**Bridey Rudd**

**Using I.ROC to measure personal recovery in survivors of complex psychological trauma**

***Introduction***

I.ROC is a 12 item personal recovery outcomes measure developed by practitioners and people with lived experience of mental health issues, for use as a facilitated or self-assessment (Monger et al., 2013). The tool was included in a battery of assessments measuring symptoms, functioning and recovery as part of a pre-post study investigating the effectiveness of a group-based Compassion Focused Therapy intervention for survivors of complex psychological trauma. People who have experienced complex traumatic events (stressors that are repetitive, prolonged or cumulative, usually interpersonal in nature and occurring at developmentally vulnerable times in the victim's life (Curtois & Ford, 2009)) often experience complex posttraumatic reactions including symptoms of Posttraumatic Stress Disorder, alongside interpersonal problems, negative self-concept and affective dysregulation (Cloitre et al., 2013). Whilst the aim of the main study was to evaluate this intervention, it provided an opportunity to assess the validity and reliability of I.ROC within a new and specific population.

***Method***

Pre-test evaluation data was included within this secondary analysis. Participant demographics and I.ROC scores were collected alongside three other measures included in the study: the Rosenberg Self-Esteem Scale (Rosenberg, 1965), the Hospital Anxiety and Depression Scale (HADS, Zigmond and Snaith, 1983) and the Work and Social Adjustment Scale (WSAS, Mundt et al, 2002).

***Results***

Results of this study, including factor analysis, internal consistency, and convergent validity of I.ROC will be presented during this presentation.

***Discussion***

These results will be discussed in relation to the validity of I.ROC as a measure of personal recovery for use within a complex trauma population, and the subsequent implications for practice. Discussion will also highlight the role of self-report measures within therapeutic relationships.

**Parallel Session 5.5**
**Theme: Re-situating recovery**
**Room: LT6**

**Daniela Sangiorgi**

**Designing for co-production: The case of developing a recovery approach in a mental healthcare service**

***Introduction***

In contemporary debate about public service innovation, particular attention has been given to the potential of developing a "more co-operative form of governing" based on co-production (Osborne, 2010) intended as the involvement of (service) users in the design, management and evaluation of public services (Osborne et al., 2016). This abstract reflects on the implications of designing for co-production in a public sector organisation, starting from the experience of an action research project of the Departments of Design and Management Engineering of Politecnico di Milano with the Department of Mental health (UOP23) of Spedali Civili di Brescia (Italy). After establishing the first Italian Recovery College in collaboration with ImROC project the UOP23 aims to contaminate other services promoting a deeper cultural change oriented toward co-production.

***Methods***

The one-year project has integrated expertise on collaborative service design, service evaluation and change management, and has funded the work of a 'designer in residence'

for six months by the premises of UOP23 in Brescia. The designer and research team conducted an iterative process of analysis, co-design sessions and prototyping that led to the activation of a 'Recovery Co-lab' intended as an experimental approach and team of people able to continue and inform this transformation across the different services of UOP23 beyond the duration of the project.

***Results and Discussion***

This presentation will discuss how the application of collaborative service design approaches helped to support UOP23 to:

- Identify and expand on existing promising practices and conditions (e.g. flexibility, informality, transparency, etc.) that seem to favour more equal interaction modes;
- Imagine possible developments beyond the constraints of a dominant culture and regulation that is still built on "average patients" and on vertical models of governance;
- Learn how to design for graduality, meaning developing solutions able to accompany users and staff in a gradual journey toward increased participation.

**Kristin Ørjasæter**

**Transforming identities. Engaging in participatory arts for people with mental health problems**

***Introduction***

People with long-term mental health problems may struggle with identity confusion, lacking a positive sense of self and having internalized an illness identity. Transforming to a healthy and positive identity is important in a recovery process.

***Method***

In this study, we explore persons´ identity transformations through participation in a music and theatre workshop. The music and theatre workshop is a non-therapeutic activity taking place in a Norwegian mental health hospital, created for adults living with long-term mental health problems. This qualitative study uses a hermeneutical phenomenological approach. Data were collected from in-depth interviews with 11 participants, analysed through a narrative thematic analysis and presented in an ideographic "long" narrative form.

***Results***

We identified three preliminary themes through the analysis: becoming a person, moving away from a narrow identity as a mental health patient, and developing an artistic identity. Life consists of various identity transformations, but dependent on the range of opportunities. We argue that the music and theatre workshop is perceived to be such an opportunity for people with mental health problems, because of its potential in generating positive and healthy identities among the participants. The gift of this arena, is its ability to accommodate the whole person, and their strengths and weaknesses at the same time. It permits the person to feel uncontrolled, to be who they are and to explore their undiscovered facets of themselves in collaboration with others interested in arts. These combinations, a sense of belonging to the group and the importance of using themselves when portraying a character, provides the opportunity to look beyond mental health problems and could function as an inner self-discovery journey.

**Raphael Bouloudnine**

**Multi-counselling management as a practical response to recovery**

***Introduction***

Multi-counselling is a method, which can be used with users of social and health services who are not at ease with the "case management" model. Users insisted they were not "cases" and they did not wish "to be managed" . Instead, they felt the need to have a set of services at their disposal which enabled them to manage their own lives.

***Methods***

In this context in order to liberate the user and the professional from an exclusive relationship, our team has developed the concept of multi-counselling. In this way, the

user is his/her own "case manager". The team is there to provide a consistent message focused on people skills. As with a Russian doll, the team, as a whole and each individual professional, create layers of multi-counselling, such as theories on education, the recovery philosophy or the systemic concepts but also through experiential knowledge.

***Result***

With this definition, the link between multi-counselling management and recovery seems obvious. Our idea of the principle of the recovery process is as follows:

- To be aware of each clients' existence as a person and citizen
- To promote skills, to encourage dreams and hopes,
- To help them move towards a meaningful life,
- To create a context in which they feel safe to explore their fields of possibilities.

***Discussion***

Multi-counselling tries to answer these dimensions by considering the whole person in the complexity of his/her own world.

## POSTER PRESENTATIONS

**Poster 1**
**Ian Kagathi**

Mental health in Kenya is 'one of those tabooed topics'. There are a lot of myths about the causes of mental illnesses, the main one being that it is concerned with witchcraft, which is well fuelled in this African setting. Due to this kind of perception, coupled with a lack of government influence in terms of administration and legislation, the management of mental illness has fallen to non-government organisations. These organizations are more concerned with research of specific illnesses rather than general mental health conditions. There is much ignorance in the general population about mental health. The presentation will seek to improve mental health and prevention in Kenya by intending to force the government formulate policies in mental health that will lead to a better nation.

**Poster 2**
**Nina Hallett**
**New ways to recovery**

This poster presentation describes the development of a new recovery based initiative at London South Bank University and focuses how it has benefited the recovery process for its members. The People's Academy was developed by mental health service users and experts by experiences in 2015 and is part of the LSBU's School of Health and Social Care. The People's Academy has since become a hub for experts with experience of mental health and their carers and has become central to providing a vehicle to assist recovery by sharing of knowledge and skills around mental wellbeing. The People's Academy is based on participation and engagement and designed to mirror the needs of its members and wider community. It does this by getting the opinions of health and care service users to build a detailed picture of what people actually want and require as part of individual recovery and wellbeing.

The role of the People's Academy is varied and has been invaluable in developing students within the University with best care practices in mind to provide person centred care acknowledging the experiences of the people they will serve. This has had a positive effect on the People's Academy's members and bought a number of benefits including putting people into education to develop both academic and practical skills, increasing individual self-esteem and confidence and enabled them to regain responsibility for their lives by increasing choice, inclusion through offering respect. Several members have benefited from a number of employment and community-focused initiatives, which the People's Academy takes part in to create awareness of mental health. The People's Academy at LSBU is capitalising on improved health and well being for all, as we all have a role to play in shaping how we modernise health and social care services This is I keeping with our vis ion for recovery as we become a recognised resource for people participation in health and social care that helps to tackle real life issues from the people who know first-hand about using those services.

The poster examines the benefits of the People's Academy in detail and how it has helped individuals to widen their understanding of their own recovery and what it means to different people and groups is essential to the understanding of recovery and what it means to individuals and different groups.

**Poster 3**
**Tianming Zhang**
**Internalized stigma, social interaction, social support and recovery among mental health consumers in rural China**

***Introduction***

Internalised stigma, an adverse psychological process, severely impedes the lives of many mental health consumers and restricts them from social integration and recovery. Nevertheless, it is not clear the mechanism by which internalised stigma influences affect

recovery among those people in rural China. Thus, this study is to empirically evaluate an integrative model for how internalised stigma influences important outcomes related recovery among mental health consumers in rural China.

***Methods***

A total of 453 persons with schizophrenia, major depressive disorder, or bipolar disorder in a rural community participated in the study and completed the measures of internalised stigma, social interaction, social support, social functioning, and symptom severity. Path analyses were used to test the integrative model for the relationships between the variables.

***Results***

Internalised stigma was moderate and severe with 94.7% of the persons with schizophrenia, major depressive disorder, and bipolar disorder in a rural Chinese community. The results from the model revealed that internalised stigma decreases the level of social functioning and symptom severity. Also, the results showed that these relationships are mediated by the impact of internalised stigma on social interaction and social support.

***Discussion***

Internalised stigma affected social interaction and social support of people with the severe mental disorder, and played a detrimental role in leading to negative outcomes to their recovery. It is essential to tailor interventions related to reducing internalised stigma and evaluate the effect of anti-stigma strategies on recovery for mental health consumers.

**Poster 4**

**Louise Canacott**

**Does the Wellness Recovery Action Plan (WRAP) contribute to clinical and personal recovery? A systematic literature review.**

***Introduction***

The Wellness Recovery Action Plan (WRAP) is a structured approach to illness self-management which may be applied to physical and mental well-being. It is currently implemented internationally with many studies reporting positive outcomes. The WRAP is recognised as an evidence-based programme by the United States Substance Abuse and Mental Health Services Administration (SAMHSA). However, despite its evidence-based status and widespread implementation, there is little published research relating to the outcomes of the WRAP and to date there has been no synthesis of the available evidence.

***Methods***

This review appraises and summarises the evidence on the effects of the WRAP on clinical and personal recovery. Studies which assessed the impact of the WRAP on clinical recovery domains, such as scores on standardised clinical outcome and/or scores on validated recovery outcome measures were included and assessed for quality. A meta-analysis was performed on data obtained from studies which assessed change on clinical outcome measures following exposure to the WRAP intervention. A further meta-analysis was performed on data from studies which assessed recovery using standardised recovery outcome measures following exposure to the WRAP intervention. Qualitative data was subjected to a thematic synthesis to identify themes relating to outcomes of the WRAP intervention.

***Results***

Preliminary results from meta-analyses indicate a non-significant effect of the WRAP on clinical symptomology. However, the secondary meta-analysis identified significant effects of the WRAP on recovery. This is further supported by the outcomes of the qualitative thematic synthesis.

***Discussion***

The finalised results will be presented in the context of the recovery model, recognising both the strengths and limitations of this analysis.

**Poster 5**
**Hilal Aydoğdu Durmuş**
**Effect of cognitive behavioural therapy in recovery in affective disorder**

***Introduction***

Affective disorder is a disorder that cause breakdowns in professional, social and relation areas due to its early onset and chronical characteristics which adaptation to disease and treatment plays a significant role. Affective disorders require long term medication. But despite affective disorder stabilizers, the relapse ratios reach to 73% in five years and 30-50% of individuals don't take their medicines. The main reason of relapse is the low adaptation ratio to medicine use. The main reason of inconvenience is attitudes and thoughts subject to affective disorder. Cognitive behavioural therapies (CBT) are good options in treatment in preventing relapses.

***Methods***

While literature search, keywords "affective disorder, recovery, mental recovery, CBT" are used.

***Results***

Recovery includes acknowledge, understanding, managing of symptoms, positive perception of experiences, changing of behaviours and values. Individuals with affective disorder in depressive period generally consider themselves and life unsatisfactory, disincentive, meaningless and the world in general as a place full of sorrow and pain. When he considers future, individuals believe the problems will get worse and they feel desperate. In their manic periods, individuals considers themselves as valuable and beloved, appreciated and outer world as a place that serves extraordinary chances and future as equipped with limitless opportunities. And in remission we can speak about an individual who feels challenges to accept his disease and consequently doesn't have regular medicine use. Due to these attitudes and thoughts, adaptation to medicine treatment and relapses increase. Recovery of individuals with affective disorder, becomes possible with CBT where cognitive processes are considered and behavioral changes are provided.

***Discussion***

The studies determined that CBT decreased the severity, duration and frequency of hippomanic and depressive symptoms, anxiety levels of individuals and cognitions, frequency of relapse, and need for hospitalisation, improved psychosocial functionality, increased adaptation to treatment and life quality. It's also determined that, it has positive effect on perception and dealing with stress.

**Poster 6**
**Debbie Butler**
**Recovery techno-style: co-producing and delivering a course on digital technology for mental health**

***Introduction***

During 2016, MindTech and its Involvement Team co-produced and delivered a 6-week course 'Recovery Techno-style' for Nottingham Recovery College aimed at introducing technology and teaching mental health self-management using information and peer support websites, apps, social media and games. We describe and reflect on the co-production process, course content and delivery.

***Methods***

The College's course development process was used requiring careful documentation of the co-production process, with templates for learning objectives and teaching methods. Co-production sessions (10 service users, 2 researchers and 2 college staff) ran November 2015-August 2016: 2 open meetings to discuss the scope and purpose of the course and 10 core team meetings to collaborate on course and session content.

***Results***

The course ran 2 hours a week in November/December 2016 with 12 students enrolled. The original scope changed significantly through the open meetings. Researchers had

ideas about what knowledge they could share, whilst service users suggested covering basic skills e.g., how to get online. The final content was a melding of perspectives to produce a comprehensive course for varied prior experience. Students accessed unfamiliar websites e.g., NHS choices; self-assessed need for new tech; one returned to previous digital habits e.g., vlogging; all tried out new techniques e.g., games for distraction.

***Discussion***

Shared control of all aspects of content, from initial scope to detailed content, required professionals to handle service user needs and expectations, sometimes expressed in a strong manner and taking them out of their domain knowledge comfort zones. Our approach to multi-level involvement made sure involvement was sustained throughout.

Students with lower confidence and prior skill probably gained most, but we maintained interest of those with more knowledge who shared it with other students. This is a labour intensive way of promoting digital technology for recovery but learning in a peer group proved valuable.

**Poster 7**

**Mang Wun Hung**

**Develop a peer support training program for promoting Recovery Concept in Hong Kong Public Hospital Mental Health Service**

***Introduction***

Peer support is “offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations”. It is one of the key principles in the transformation of recovery-oriented system in Hong Kong mental health services. Evidences have shown that peer support can contribute roles of providing support, facilitating self-management, reducing stigma in the public. Public hospitals in Hong Kong has started employing peer support workers (PSW) since last two years and plans to roll out to more clusters afterwards. The Community Psychiatric Service of Department of Psychiatry collaborating with Occupational Therapy Department in Pamela Youde Nethersole Eastern Hospital (PYNEH) have designed a PSW training program consists of 10-session lecture and four-month practicum training, aiming at preparing potential interested candidates to develop the essential skills and knowledge, including mutual problem solving skills, wellness and personal recovery planning, team working, recovery storytelling skills, code of conducts and ethical considerations. This study is to evaluate the effect of PSW training program on peers’ hope, self-esteem and self-efficacy.

***Methods***

Single group pre-post measurement design is used to evaluate its effectiveness. The Chinese General self-efficacy Scale, Rosenberg Self-Esteem Scale-Chinese Version and Herth Hope Index Chinese are chosen and completed by each participants at intervals of pre and post program respectively.

***Results***

From July 2015 to February 2017, two classes has been run. Total 15 participants join the program. All participants have completed the pre and post measurements. Preliminary outcome shows slight improvements in all assessment tools. However, no significant findings are found due to small sample size.

***Discussion***

The overall feedbacks on the program are satisfactory. They all agree that the program equips their skills and competence on achieving the role of a PSW. Besides, the program also allows them to review their recovery journey and instill new viewpoints about that.

**Poster 8**

**Kristin Ørjasæter**

**Acting Out. Enabling Meaningful Participation**

***Introduction***

People with long-term mental health problems participate less often in cultural activities than the general population. Many find it difficult to both find and maintain activities

because of their mental health condition, or not accessible activities.

***Method***

In this article, we explore what enables meaningful participation in a music and theatre workshop from a first person's perspective of people with mental health problems. The study uses a hermeneutical-phenomenological approach. Data were collected from qualitative in-depth interviews with 12 participants in a music and theatre workshop located in a Norwegian mental health hospital. Data were analysed through thematic analysis.

***Results***

Two overarching themes were identified: (a) room for dignity and (b) a creative arena. This study indicates that to enable participation for people with long-term mental health problems, it is important to facilitate activities that are flexible, person centered, and resource oriented, in which participants have the possibility to participate regardless of symptoms, functional ability, or whether they are hospitalized. In addition, having professionals who believe in creative growth and offer an illness-free zone that belongs to the participants in a hospital setting is of great importance.

**Poster 9**

**Wong Tsz Yan**

**Recovery-oriented approach in vocational rehabilitation for people with mental illness in Hong Kong**

***Introduction***

Stigma of mental illness is prevalent in Asia under the sociocultural influence. People with mental illness are always considered as aggressive or low competency. Although various vocational services are available in Hong Kong, the unemployment rate of people with mental illness was high. Difficulties in accessing the fragmented vocational services and social stigma are key factors hindering client's recovery.

Hence, an Early Integrated Vocational Services (EIVS) was established to provide timely job placement through the recovery-oriented strategies:

1. Instilled hope and formulated individualized work plan with psychiatric patients in admission wards
2. Facilitated self-direction and choice via development of job bank, with integrated vocational services and competitive jobs to widen client's choices in job matching
3. Holistic on-the-job support including psychological and social support to clients and employer engagement
4. Promoted acceptance and eliminated stigma by educating employers the adapted working practices and facilitated a positive employment relationship

***Methods***

Evaluate the effectiveness of EIVS in enhancing vocational recovery for psychiatric patients via collecting employment rate, job nature and satisfaction surveys of service users after 4-month of discharge.

***Results***

There were 66 service users from 12/2014 to 10/2016. The successful employment rate was 56.1%. Among the successful employed users, 47.8% users were placed to Open Employment (OE), 50% users were placed to Supported Employment (SE), 2.2% users were placed to employee retraining course. Up to 73% and 66.7% of the users in OE and SE sustained the job up to at least 3 months. Over 90% users agreed the EIVS program facilitated their recovery and improved their self-esteem in community.

***Discussion***

The working model emphasizing a recovery-oriented approach with consolidated vocational platform, seamless bridging and rapid job placement is more effective for psychiatric patients to attain successful employment. On-the-job support is crucial in prompting clients' reintegration to community.

**Poster 10**
**Emma Joyes**
**Creative practice as mutual recovery within forensic mental health**

***Introduction***

This research is funded as part of a larger AHRC/RCUK Connected Communities grant, and is entitled 'Creative Practice as Mutual Recovery (CPMR): Connecting Communities for Mental Health and Well-being'. The programme investigates how creative practices from the fields of the Arts and Humanities, such as creative writing, painting, literature, drawing and singing, may afford an opportunity for mutual recovery of mental health and well-being among staff/carers and those receiving care from mental health services. This research explores the creative practices which occur within one inpatient Forensic Mental Health (FMH) hospital site. It considers their contribution to well-being and the potential for creative practices engaged with by staff and/or residents to be of reciprocal or mutual value.

***Methods***

An ethnographic research design explores the possible contribution of creative practice to well-being for the staff and Forensic Mental Health (FMH) population across three units within one service. The methods include overt participant observation, documentary analysis and semi-structured interviews. The ethnographic approach is congruent with the exploratory nature of the aims of this project. The research design is purposely iterative so that the concepts such as creative practice, mental health and well-being and the emergent concept of mutual recovery can be investigated within the interpretivist tradition.

***Results***

This paper reports the salient themes and preliminary data excerpts from the observational fieldwork and the semi-structured interviews conducted with residents and staff at the service.

***Discussion***

The importance of relationships, including the resident (service user) and professional encounters framed within the context of creative practice are considered. The research contributes to the recovery literature broadly but also interrogates the possibility of mutual recovery within the FMH context, thus contributing to the discussion around defining boundaries of the concept.

**Poster 11**
**Norha Vera San Juan**
**What does recovery from mental disorders mean to users and informal carers in Latin America?**

Culture is considered central to the concept of recovery; if ignored it can be a barrier to the development of appropriate and adequate mental health services. There is little understanding about recovery in Latin America; identifying users and informal carers' beliefs about recovery and what factors they consider most relevant will provide a conceptual framework for the development/adaptation of a recovery questionnaire appropriate for use in the region.

In-depth qualitative interviews about knowledge, experiences and perceptions of recovery from mental disorders will be conducted with service users (n=30) and informal carers (n=30), in Chile and Argentina.

Using a bottom-up approach to explore how participants conceptualise recovery, individuals will be asked open-ended questions about their experiences in relation to personal recovery; if they have a notion of the concept of recovery; and what factors they consider are relevant to recovery. Questions about the link between recovery and culture-specific aspects considered likely to have an effect on recovery in Chilean and Argentinian culture will follow. Also, they will be asked about the relevance of the dimensions of recovery presented in existing models of recovery from outside Latin America. Specifically the relevance of the following dimensions of recovery will be addressed: Connectedness; hope and optimism; identity; meaning in life; empowerment; and resilience.

The information collected from the in-depth interviews will be analysed using NVivo software to identify and analyse themes or patterns in participants' responses. Careful attention will be paid to detecting culture-specific aspects of recovery, following the What Matters Most theory. Within this theory, culture is defined as the activities that "matter most" to the participant and define "full status" within a cultural group.

**Poster 12**
**Mar Garcia-Franco**
**Employment strategies for people with mental illness. IPS approach.**

***Introduction***

SIL of Esplugues is a supported employment team of Parc Sanitari Sant Joan de Déu, it is a mostly dedicated to mental health institution. The aim of SIL service is to facilitate the possibility of people diagnosed with a mental disorder to find a job, but in a competitive employment. This service is functioning for more than 15 years. Its area of atention is currently in to 2 cities of Baix Llobregat, in Barcelona, Catalonia (Cornellà and Esplugues). The service uses the Individual Placement Support approach since 2013 (Darmouth University). This methodology identifies the capabilities of the people with severe mental illness who are motivated to develop a laboral project. Usually people with a psychiatry diagnosis find difficulties to get a job, or to have the resources to find a workplace in equality conditions. In the other side, the employment specialists make relationships with employers, looking for the clients' preferences.

***Method and Results***

The team are 4 employment specialists, a supervisor and a service Coordinator. Their main task is to support the users in the process of elaboration and development of their educational and/or employment project. During the process, the team respects the interests of each person and support actions are suited to each situation. SIL operates with community mental health services. The primary outcome assessed during 2016 are very suggestive. From the 160 people attended. Of these, 78 people have been able to find a job and 50 people have chosen to continue studying. Other analysis are clients' employment preferences, clients' diagnosis and vocational interests.

***Discussion***

The results suggests that the intervention is effective, and this kind of approach make possible that person with a mental illness can get a job, and can keep on it.

**Poster 13**
**Glòria Comellas**
**Changing concepts: recovery and person-centred attention. From 1992 to 2017 in Barcelona**

***Introduction***

In 1992, the Day Centre (CD) is defined as an intermediate structure, including the circuit care and mental health promotion aimed at containment, rehabilitation and reintegration of the Socio-psychiatric patients over 18 years with serious psychiatric disorders, needs support in order to live more independently as possible in the community. It is aimed at people diagnosed with chronic psychosis (not in an acute phase or production) and their social reintegration and family.

***Methods***

Actually, as a Community Rehabilitation Service (CRS), are committed to a new model of CRS mental health entails expanding the concept of psychosocial recovery. It is aimed to people with several mental disorders, more than 16 years that presented: relational or social isolation. Disruption of daily life. Inappropriate use of community resources. Families overloaded or feelings of failure. It is based on an integral concept of the person, as opposed to conventional psychiatric treatment had more in mind the reduction in positive symptoms and focuses on disabilities, the new model of recovery focuses on the capabilities of the person.

***Discussion***

The psychosocial treatment at the community has changed from a group-focused

intervention to a person-centred model of care focused on the interaction between the individual and the context, and the activation of personal resources of the individual, promoting changes in the various areas of this situation psychosocial aimed at improving their quality of life. The complexity of recovery is wider than the symptoms improvement.

**Poster 14**
**Simone Arbour**
**Establishing meaningful change parameters for the Recovery Assessment Scale**

Using assessment tools to help guide treatment planning and gauge improvement is common across a variety of treatment settings. However, the use of measurement based care as it relates to recovery from mental illness is not as common. The purpose of the presentation is to outline a strategy for the application of a recovery-based measurement tool into practice at a tertiary mental health hospital in Canada – namely the Recovery Assessment Scale (RAS). The RAS is widely used as an outcome measure in program evaluation and in mental health research. It is a self-reported measure based on a process model of recovery and has a special focus on hope and self-determination. We intend to outline a practical way that the RAS can be used to gauge meaningful change in service users seeking help for serious mental illness. Studies employing the RAS commonly use repeated measures designs in which outcomes are determined by comparing pre-post differences in scores. However, as samples become larger, it is possible for small differences that may not be clinically meaningful to reach statistical significance. Therefore it is relevant to establish meaningful change as it relates to recovery-oriented metrics. Data will be presented using RAS scores from a number of clinical populations within the hospital, establishing benchmark and "meaningful change" parameters for the RAS. As more and more mental healthcare facilities in Canada aim to influence recovery-related outcomes for their service users, it is pertinent to operationalize the use of the RAS in order to inform collaborative recovery goal setting among services users and clinicians. The application of this measurement tool can therefore be used to assess change in recovery outcome and refine care plans to influence facets of recovery that are important to the service user.

**Poster 15**
**Kirsty Locker**
**Moving On: The journey through a medium secure unit and beyond**

***Introduction***

Previous research has shown that leaver's groups can alleviate anxieties relating to discharge - a time which can provoke fear and uncertainty, as well as joy. Having established a Moving On group at the Trevor Gibbens Unit (TGU) in August 2016, researchers attempted to evaluate the experience of service users who attended the weekly group, in order to establish its efficacy and impact on preparing clients for moving on. As this was the first time the group had been run in its present guise, research was deemed necessary to improve patient experience by implementing relevant recommendations.

***Methods***

The voluntary sample comprised of current male patients at the TGU who had attended the group on at least one occasion. The sample consisted of 5 patients from across two wards. Data collection took place during March 2017, using a specially designed quantitative & qualitative questionnaire. Data was collected by two Recovery Leads who had been running the group. Patients who agreed to take part were given a blank copy of the questionnaire to fill in themselves, with the option to remain anonymous. Patterns in the data were sought, analysed and recommendations offered for future running of the group.

***Results***

Results found service users 'mean average response for satisfaction with the group was 4.6 out of 5. The top three sessions as chosen by service users were: Healthy Eating, Where Next? and General Health and Support. When asked, 100% of the sample stated

they would recommend the group to others.

***Discussion***

Group work is clearly beneficial for clients when preparing for discharge and moving on. Findings should be shared with staff who wish to facilitate a similar group for female patients. Future sessions should involve more guest speakers as these were some of the most popular.

**Poster 16**

**Michael Schwartz**

**Diversity: A foundational perspective for mental disorder**

***Introduction***

Presently, there is a strong global consensus in democratic societies to value all sorts of human diversity (racial, ethic, gender, physical, social). No!!! In fact, such diversity is embraced ONLY if we behave within increasingly narrow and restrictive norms. Behaviourally, we increasingly embrace “conformity” rather than “diversity”

***Methods***:

Narrative.

***Results***

As “community” fades and is replaced with “society” – we are increasingly estranged from each other. All relative strangers, we easily mistrust each other, hence the need for narrower and narrower norms of social discourse and conduct. In consequence - you can be of any race, gender, ethnicity or culture - so long as you behave. And if you do not/cannot? Mental illness is increasingly suspect/diagnosed.

***Discussion***

Humans are the most diverse of all species, except for our pets and domesticated animals. Good: Our diversity is one of our greatest strengths – enabling us to populate widely across the entire globe. The example of racial diversity validates the above. Ranging in skin colour from pale to dark with all sorts of shades in between, humans can nonetheless all cross-breed. Notably, such diversity brings both advantages and vulnerabilities: Lighter-skinned humans can dwell in the northern latitudes and get adequate sunlight (re Vitamin D), but they require more sun-screen in the tropics. In contrast, darker-skinned humans - protected from the sun via melanin, can dwell more easily in the tropics – but often require supplementary vitamin D in artic latitudes. In a similar manner, behavioural diversity offers strengths under some circumstances and vulnerabilities under others. Some of these strengths – culture-creating visionary creativity (documented association with schizophrenia); building the new culture (documented association with depression); needed creative post-modern destruction (documented association with anti-social personality); and end-of-era preservation (associated with anxiety and OCD) – will be clarified in this presentation.

**Poster 17**

**Naniyati**

**The significance of processing speed in Cognitive Remediation for patients with first episode psychosis**

***Introduction***

Cognitive dysfunctions are prevalent in schizophrenia which associated with functional outcomes. Studies towards recovery in the area of psychosis through Cognitive Remediation (CR) is paramount to enhance global cognition, psychosocial and symptoms reduction by concentrating the core deficit.

***Methods***

This parallel single blinded with two-arm trial involved 104 FEP participants of Remediation of Mind (ReMind) program from Klang Valley hospitals in Malaysia. Participants were randomly allocated to compare the effect of adding PS in CR (n=52) to standard CR (n=52) as an active comparator for 15 sessions of web based cognitive training over 8 weeks with a month follow up session. The effects of 10-hour targeted skill in PS were examined in this metacognitive-based CR. The neurocognitive and real world

functional measures were used prior to intervention as baseline, pre and post assessment comprising The Brief Assessment of Cognition Schizophrenia Malay Version (BACS-M), the Positive and Negative Syndrome Scale (PANSS), Schizophrenia Cognition Rating Scale (SCoRS), Social Functioning Scale (SFS), and Schizophrenia Quality of Life Scale Revision 4 (SQLS-R4). The mixed model one way analysis of variance (ANOVA) was used to compare the difference between the mean of pre and post treatment. While Multiple Linear Regression analysis analysed the effect of intervention, symptom and outcomes.

***Results***

The significant effect size for global cognition of d= .45 were identical to cognitive domains and d= .41 in recent and previous meta-analysis respectively. The processing speed is remarkable as mediator to boost cognitive abilities and psychosocial.

***Discussion***

Findings of the study revealed that targeting lower-level cognitive process of processing speed is vital for higher-level performance in cognition, daily functioning and symptomatology in FEP. The adjunct rehabilitation via inference of metacognitive strategies with therapist support were the active ingredients which accounted for impactful real-world outcomes.

**Poster 18**

**Malcolm Watson**

**Creating a prevention rather than cure approach to mental health**

***Introduction***

I have created a unique self help tool for people with GAD that has netted amazing trial results. This was created from the view point of being an expert by experience rather than a formally trained academic.

***Method***

The method I created was based around mindfulness and MBCT but is portable, low level and effective without the need for intervention by the medical profession. At a time when mental ill health is on the increase but many people, particularly males, refuse to talk about it, a simple self help tool has great value.

***Results***

A 100% success rate that has also seen someone with a serious mental condition start the road to real recovery. It has helped another cope with meetings, cease medication and another return to employment!

***Discussion***

Why is this being ignored by the NHS and how can we deliver it to the people who need it and create a true prevention rather than cure approach to mental health?

**Poster 19**

**Ashley-Christopher Fallon**

**“Focusing on the prosocial amidst the antisocial” – how forensic mental health service users appreciating each other motivated the system**

***Introduction***

In the UK prison population, the prevalence of people with antisocial personality disorder has been identified as 63% in male prisoners. A potential concern in forensic environments is the density of service users who endorse antisocial lifestyles. Much of the work in forensic hospitals is led by professionals aimed at reducing problem behaviours however less time is spent on service users themselves promoting prosocial behaviours or rewarding them when they occur. The “Appreciation Awards” is a pioneering annual ceremony where service users coordinate, nominate and recognise the positive achievements of both peers and staff members, no matter how small. Entirely led by service users, the project is recognised as empowering and enabling, likely to benefit wider cohorts within the wider forensic service.

***Methods***

A small cohort of male service users (n = 4) within one medium secure hospital pitched in

hospital Recovery, Outcome and Wellbeing (ROW) Meetings for resources to deliver a specific service user-led and recovery-focused activity - a celebration ceremony for the service users resident on one ward. Named “The Appreciation Awards” this involved all service users nominating peers and staff members for one significant and positive trait (ranging for example, from “provides the best summary of the news” to “helping me understand the care team process”) that they then received a certificate for in an open ceremony.

***Results***

Overall, the Awards took 6 months to plan including 21 meetings with the service users, monthly ROW meetings and hundreds of man hours. Over 300 nominations were collected and sorted through, certificates typed, printed and laminated by service users with the support of staff. Due to the level of service user engagement in the Awards, the Trust recognised the achievement; it was submitted for and has been nominated for “Outstanding service user achievement award” at the National Service User Awards 2017.

***Conclusions***

Service users fedback that the Awards process improved morale, sense of esteem and recovery focus. Staff fedback the relational environment was improved in that collaborative working improved and innovation was encouraged. The success means the Awards will initially be rolled out to the whole hospital and it is planned that the other hospitals within the directorate will also have the opportunity to take part, thus the Awards will become a larger scale venture.

**Poster 20**

**Ashley-Christopher Fallon**

**“Adjusting to sexuality within an asexual world” – encouraging awareness of sexuality within a male forensic mental health service**

***Introduction***

Research demonstrates that LGBT-specific needs are not considered in healthcare provision (Stonewall, 2012). Further, LGBT service users face stigma, discrimination, and invisibility within services; resulting in poor engagement and unmet needs (CAPS & LGBT Health, 2012). Within secure care, concerns also exist that discussions of sexuality may aggravate the mental health of service users; though no specific research supports this. To open conversation about LGBT-specific needs, one male medium secure service dedicated a month to sexuality awareness.

***Methods***

There were 3 core areas of activity;

1) Direct consultation and discussion with Service Users
2) Developing and exchanging written materials
3) Utilising external LGBT materials and adapting these for secure services.

Service users collaboratively created a series of leaflets, including 2 personal disclosure pieces regarding being LGBT in services. Responses were invited, to be presented at an afternoon event. 25 people, across twelve 60-minute groups, met to discuss stigma, discrimination, and how sexuality is talked about in services. A “Pride Tree” was produced by service users, celebrating things people were proud of.

***Results***

The month was generally well received. The groups were well attended, generating interesting conversation. Responses to the personal disclosure pieces were overwhelmingly positive, with 7 service users expressing support and encouragement. Service users valued the opportunity to speak with professionals about sexuality and relationships. Thirty service users attended and engaged with the materials for the final “Pride” event.

***Conclusions***

The month’s successfulness, with around 1 in 3 service users engaging, demonstrated that sexuality can be addressed in male secure environments in a safe and valuable way. The month will return, building on this year’s successes and learning. One goal is to include outside organisations, i.e. Birmingham LGBT association, to develop community

links. Another is to engage more staff; addressing the institutional discomfort and inexperience around discussing sexuality.

**Poster 21**
**Anneliese de Wet**
**The development of an evaluation measure for a novel recovery programme at a public psychiatric hospital in the Western Cape, South Africa**

Programmes promoting recovery have proliferated in the past few decades and many have been found to be effective. The effectiveness of such programmes are measured largely in two ways, either by measuring personal recovery or by measuring the recovery orientation of the service providers or systems. Internationally, many measures have been developed, tested, implemented and adopted to do such evaluations. Mental health recovery programmes have also been implemented more recently in South Africa. In South Africa, however, measures to evaluate have not been widely implemented nor have locally-appropriate measures been developed yet. The problem being addressed by this doctoral study is the development of a locally-appropriate measure for personal recovery and the recovery-orientation of service providers in one such novel programme, which includes a wheelchair clinic, an identity document project and a market garden and where the focus is on recovery through hope and re-connection, at a large psychiatric hospital in the Western Cape province of South Africa. The evaluation of the programme is crucial to 1) determine to what extent the programme contributes to the achievement of recovery, 2) ensure the quality and integrity of the programme, 3) be able to adapt the programme to continually be more effective, especially in a resource-poor setting such as South Africa and 4) satisfy funders as to the successful appropriation of their funds.

**Poster 22**
**Hannah Steer**
**Hopeful Recoveries: a shared learning event**

We present an exercise in gaining meaningful service user and carer feedback. This aimed to improve the service environment and delivery of care (in line with best practice guidelines). It also provided an opportunity to consider what helps in recovering from mental health problems. This was done through a joint event for service users, carers and staff in a community setting. A wealth of discussions took place, highlighting issues for people regarding their views of the meaning of recovery from mental illness. Outcomes were that participants fed back that they benefitted from the experience. Qualitative feedback demonstrated that the event enabled learning, supporting and building relationships. Improvements to the inpatient recovery environment were identified, and the shared learning event will be repeated on an annual basis.

**Poster 23**
**Sam Kozak**
**Process of development and evaluation of a mobile digital mental health intervention in community settings using the 'My Journey' tool**

A collaborative, co productive approach was used to identify professional and service user needs and gaps in existing care processes, which informed the design of the digital health intervention. This was intended to enable care planning to become more service user centric, recovery focussed and collaborative. The tools were aligned with organisational needs to improve the process of care planning and service provision to support recovery orientated approaches. An evaluation of the impact of the 'My Journey' digital recovery planning tool using qualitative methods concluded that using the tool had a positive impact on recovery focused practice and service user experience. Clinicians and Service Users felt the recovery oriented design of the tool was valuable in adding structure and the format helped facilitate conversations in sessions with service users. The ability for staff to co-produce progress notes with service users was felt to enhance the quality and transparency of how notes and their content was recorded about a session. The paper also explores the process and benefits of co-producing solutions in line with the Nesta principles, which were adopted throughout the design and delivery of the project.

A consideration of the process of implementation helped identify a number of challenges which impacted on the delivery of the 'My Journey' tool. Health Care Practitioners participating in the pilot and identified important challenges such as technological factors, and the need for an automated system of integration between the tool and electronic patient records. Service-user specific factors included obstacles such as digital literacy and the poverty of access to upskilling, attitudes towards technology and individual mental health and care needs. Other factors such as potential changes to changing current culture, ways of working and time pressures were acknowledged as requiring consideration, alongside wider organisation factors also had a relationship with the broader implementation of the use of the tool, such as how digitally literate the workforce is, and the level support for the project.

**Poster 24**

**Najat Khalifa**

**Individual Placement and Support (IPS), IPS implementation & employing patients with offending histories: Assessing the views of patients, mental health professionals and employers**

***Introduction***

Academic literature and government initiatives have emphasised the importance of work as a means of improving health and reducing reoffending among offenders with mental disorders. Whilst Individual Placement and Support (IPS) has shown promise in mental healthcare settings it has not been evaluated with UK forensic populations before. The complexities of forensic mental health care and attitudes of employers pose huge challenges to the implementation of IPS.

***Aims***

Semi-structured interviews will be conducted with forensic patients receiving IPS, staff with practical experience of IPS and employers. Interviews will identify patient's general views of IPS, along with exploring the benefits or disadvantages of participating and the acceptability of IPS. Interviews will explore staff's perceptions of the structural, legal, organisational and legal level barriers and facilitators to IPS implementation and general views of employers in hiring individuals from this population.

***Methods***

The aims of this study will be met by conducting semi-structured interviews with the following groups:

- Forensic patients on the caseload of the community forensic services in Nottingham who are receiving IPS.
- A purposive sample of staff, reflecting backgrounds and experiences.
- Employers who are known to employ individuals with mental health problems and offending histories and those reluctant to employ such individuals.

Anonymised transcripts of interviews will be obtained through audiotapes recorded with the interviewees consent. Interviews will be analysed using thematic analysis to identify main themes and data will be analysed using the framework approach.

***Results***

The emerging themes will be discussed. This research strand is currently in progress and as such results will be reported at the conference in September.

***Discussion***

It is hoped that by appraising the potential of this intervention, we can evaluate whether or not and how best to introduce IPS into forensic mental health settings. We will highlight the barriers and facilitators to IPS implementation, service delivery and employer engagement.

**Certificate of attendance**

You can download a certificate of attendance from the conference website http://www.researchintorecovery.com/ror2017.

Certificates will be available to download until 20 October 2017.