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Delegate List

Please note that registrations made after 22.8.2013 are not listed

Forename	Surname	Organisation
Pratik	Adhikary	Bournemouth University
Becky	Aldridge	Dorset Mental Health Forum
Daniel	Allen	East London NHS Foundation Trust
Jan	Appleton	Southern Health NHS Foundation Trust
Carole	Appleyard	Dorset Mental Health Forum
Claire	Arthern	Sussex Partnership NHS Foundation Trust
Rebecca	Ashby	Southern Health NHS Foundation Trust
Peter	Atkins	Bournemouth University
Ellen	Banyard	St Andrew's Healthcare
Sue	Barker	Bournemouth University
Jenny	Barnes	Southfield Low Secure Unit
Cherry	Barney	
Donna	Barrowman	Peer Support Network
James	Barton	Dorset HealthCare University NHS Foundation Trust
Sarah	Bateup	PsychologyOnline
Joanne	Beardmore	Dorset HealthCare University NHS Foundation Trust
Celia	Beckett	Five Rivers Partnership
Carolyn	Biggs	Dorset HealthCare University NHS Foundation Trust
Anna	Biley	
Lauren	Bishop	Dorset HealthCare University NHS Foundation Trust
Jon	Boakes	Dorset HealthCare University NHS Foundation Trust
Jed	Boardman	South London and Maudsley NHS Foundation Trust
Rachael	Borne	Care UK
Terry	Bowyer	Dorset Mental Health Forum
Charlotte	Boyde-Shaw	Priory Group
Andy	Bradley	Networks4Change
Sally	Branch	Dorset HealthCare University NHS Foundation Trust/Self-Employed
Jane	Brennan	NHS Dorset CCG
Michael	Brent	Care UK
Susan	Brooks	Self-Employed
Jodi	Brown	Dorset HealthCare University NHS Foundation Trust
Mark	Brown	Dorset Mental Health Forum
Jon	Bryant	Jon Bryant Associates
Sue	Butler	Richmond Fellowship
Jane	Carey	Dorset Mental Health Forum
Kate	Chapman	Avon & Wiltshire Partnership NHS Trust
Sonya	Chelvanayagam	Bournemouth University
John	Chilton	2gether NHS Foundation Trust
Shonna	Coleman	Dorset County Council
James	Cook	Dorset HealthCare University NHS Foundation Trust
Emma	Cosham	Surrey and Borders Partnership NHS Foundation Trust
Anna	Cosslet	Dorset HealthCare University NHS Foundation Trust

Paul	Crabbe	Dorset Healthcare University NHS Foundation Trust
Peter	Crascall	Inmind Healthcare Group
Trish	Crawford	Surrey and Borders Partnership NHS Foundation Trust
Tyler	Crow	Avon & Wiltshire Partnership NHS Trust
Jo	Culpin	The University of Southampton
Lulu	Dajani	Dorset HealthCare University NHS Foundation Trust
Meherzin	Das	Dorset HealthCare University NHS Foundation Trust
Annabelle	Davis	Dorset Mental Health Forum
Samantha	Dench	Dorset HealthCare University NHS Foundation Trust
Martin	Dominy	Southdown Housing Association
Patricia	Duckworth	Dorset Mental Health Forum
Rick	Dyer	Dorset Mental Health Forum
Jilli	Esposito	Southern Health NHS Foundation Trust
Karen	Etheridge	Rotherham Doncaster and South Humber NHS Foundation Trust
Lucy	Evans	Dorset Mental Health Forum
Richard	Evans-Lacey	Psychic Plumbing
Angela	Fiori	Surrey and Borders Partnership NHS Foundation Trust
Melanie	Gabbi	Slough Borough Council
Lisa	Gale	Bournemouth University
Lucky	Ganatra	Dorset HealthCare University NHS Foundation Trust
Lilian	Garcia-Roberts	Dorset HealthCare University NHS Foundation Trust
Darren	George	Surrey and Borders Partnership NHS Foundation Trust
Helen	Gibson	Southern Health NHS Foundation Trust
Chipo	Gono	Together for Mental Wellbeing
Kerri	Gray	Southern Health NHS Foundation Trust
John	Green	Dorset Mental Health Forum
Andy	Gritt	Dorset HealthCare University NHS Foundation Trust
Raj	Gupta	South London and Maudsley NHS Foundation Trust.
Liz	Halle	Together for Mental Wellbeing
Helen	Hardcastle	Dorset Mental Health Forum
Jacqui	Hawkins	NHS South Devon & Torbay CCG
Pete	Hill	Dorset HealthCare University NHS Foundation Trust
Vicky	Horrocks	Partnerships in Care, The Dene
Mark	Houghton	Dorset Mental Health Forum
Helen	Hutchings	Dorset HealthCare University NHS Foundation Trust
Paul	Hutchings	Dorset HealthCare University NHS Foundation Trust
Jan	Hutchinson	Centre for Mental Health
Eleanor	Jack	Bournemouth University
Fiona	Jeffries	Great Ormond Street Hospital
Ben	Jenkins	Dorset Mental Health Forum
Donna	Jenkins	Dorset HealthCare University NHS Foundation Trust
Mary	John	University of Surrey
Donna	Johnson	Southdown Housing Association
Kevan	Jones	MP
Anita	Kalia	South London & Maudsley NHS Foundation Trust
Larry	Katz	Dorset HealthCare University NHS Foundation Trust

Fiona	Kay	Andover Crisis and Support Centre
Megan	Kendall	Dorset HealthCare University NHS Foundation Trust
Naomi	Kennett	Southern Health NHS Foundation Trust
Miranda	Kersley	Self-Employed
Hannah	Kiddle	Dorset HealthCare University NHS Foundation Trust
Toni	King	Solent NHS Trust
Amanda	Kingswell	Solent NHS Trust
Andrea	Lacey	Bournemouth University
Katrina	Lahmann	Haringey Advisory Group on Alcohol (HAGA)
Kate	Law	Priory Group
Jackie	Lawson	Dorset HealthCare University NHS Foundation Trust
Ruth	Lazarus	British Association of Play Therapists (BAPT)
Elise	Leclerc	Right Here/Mental Health Foundation-Paul Hamlyn Foundation
Rachel	Ley	Advance
Jackie	Lillywhite	Dorset Mind
Douglas	Low	Richmond Fellowship
Karen	Machin	Institute of Mental Health
Kenny	Mackay	East Sussex County Council
Alex	Maguire	West London Mental Health NHS Trust
Julia	Maiden	
Adam	Marlborough	Dorset Mental Health Forum
Corrine	Maskell	East London NHS Foundation Trust
Rachael	Matharoo	Rotherham Doncaster and South Humber NHS Foundation Trust
Andy	Mayers	Bournemouth University
Louise	McCusker	Southern Health NHS Foundation Trust
Stuart	McDowell	Portsmouth County Council
Maria	McGhee	Dorset Mental Health Forum
Wendy	Meadowcroft	Dorset HealthCare University NHS Foundation Trust
Andy	Mercer	Bournemouth University
Ian	Merrick	London South Bank University
Bridey	Monger	Penumbra
Shauna	Monks	Dorset Mental Health Forum
Phil	Morgan	Dorset HealthCare University NHS Foundation Trust
Peter	Munns	Help and Care
Caspar	Murphy	Sussex Oakleaf
Naomi	Mwasambili	Community Therapies and Training Service
Inger Kari	Nerheim	Stavanger University Hospital, Division of Psychiatry
Karen	Newbigging	University of Central Lancashire
Steve	O'Driscoll	Richmond Fellowship
David	O'Loughlin	Dorset HealthCare University NHS Foundation Trust
Louise	Orchard	Dorset HealthCare University NHS Foundation Trust
Derek	O'Toole	NHS South Devon & Torbay CCG
Yasmine	Owarsh	Haringey Advisory Group on Alcohol (HAGA)
Adebayo	Oyeniyi	Advance
Kay	Paige	The Ansell Clinic
Andy	Pain	Dorset HealthCare University NHS Foundation Trust

James	Palfreman-Kay	Bournemouth University
Jenny	Palmer	Beacon UK
Louise	Palmer	JAMI
Kris	Panvalkar	Dorset HealthCare University NHS Foundation Trust
Margarete	Parrish	Bournemouth University
Beverley	Pattison	Richmond Fellowship
Helen	Payne	University of Hertfordshire
Kerry	Pearce	Dorset HealthCare University NHS Foundation Trust
Nigel	Peirce	Dorset HealthCare University NHS Foundation Trust
Rachel	Perkins	Chair of Equality 2025
Alison	Phillips	Care UK
Adam	Pickles	Dudley and Walsall Mental Health Partnership NHS Trust
Babs	Plumbridge	Dorset Mental Health Forum
Nick	Plumbridge	Dorset Mental Health Forum
Andy	Potter	Dorset Mental Health Forum
Alison	Powell	Dorset Mental Health Forum
Shane	Powell	Dorset HealthCare University NHS Foundation Trust
Jackie	Preston	Southern Health NHS Foundation Trust
Dave	Privitt	Dorset Mental Health Forum
Mat	Rawsthorne	Institute of Mental Health
Hannah	Ray	Avon & Wiltshire Partnership NHS Trust
Anna	Redding	Southern Health NHS Foundation Trust
Julie	Repper	University of Nottingham
Perpetua	Roberts	East London NHS Foundation Trust
Don	Robertson	Rethink Mental Illness
Sam	Robertson	Self-Employed
Sarah	Rose	Dorset Mental Health Forum
Seth	Rowles	Dorset HealthCare University NHS Foundation Trust
June	Sadd	University of Central Lancashire
Jill	Sammonds	Dorset HealthCare University NHS Foundation Trust
Tanya	Samuels	Richmond Fellowship
Penny	Saunders	Together for Mental Wellbeing
Paul	Scates	Dorset Mental Health Forum
David	Scull	Priory Group
Gina	Selby	Self-Employed
Nadine	Senior-Reid	Cygnet Health Care
Lucy	Sharp	Solent NHS Trust
Rosemary	Shaylor	NHS Dorset CCG
Geoff	Shepherd	Centre for Mental Health
Sheila	Shutler	Together for Mental Wellbeing
Rizwana	Siddique	St Andrew's Healthcare
Paul	Siebenthal	Dorset Mental Health Forum
Laura	Simonds	University of Surrey
Paul	Simpson	Dorset HealthCare University NHS Foundation Trust
Katy	Sivyer	Dorset HealthCare University NHS Foundation Trust
Alison	Slack	Dorset Mental Health Forum

Paul	Sly	Dorset HealthCare University NHS Foundation Trust
Richard	Smale	Bournemouth University
Brian	Smith	Richmond Fellowship
Jay	Smith	East London Foundation NHS trust
Genevieve	Smyth	College of Occupational Therapists
Lisa	Spriggs	Dorset Mental Health Forum
Nohemi	Stacey	Together for Mental Wellbeing
Linda	Stevenson	Dorset Mental Health Forum
Tony	Stewart	Staffordshire University
Jennifer	Stickney	Dorset HealthCare University NHS Foundation Trust
Cherry	Sturt	Dorset Mental Health Forum
Celia	Taylor	East London NHS Foundation Trust
Georgina	Taylor	Dorset HealthCare University NHS Foundation Trust
Lynne	Thomas	Southdown Housing Association
Denise	Thompson	Arohanui Mental Health Care
Anna	Tickle	Nottinghamshire Healthcare NHS Trust
Amanda	Tidman	Priory Group
Paul	Valentine	Southern Health NHS Foundation Trust
Louise	Van Wingerden	Dorset Mental Health Forum
Hannah	Walker	Dorset Mental Health Forum
Fran	Walsh	Nottinghamshire Healthcare NHS Trust
Jonathan	Walsh	Dorset HealthCare University NHS Foundation Trust
Andy	Warren	Together for Mental Wellbeing
Angela	Warren	Bournemouth University
Amanda	Watson	Bournemouth University
Emma	Watson	South London and Maudsley NHS Foundation Trust
Tom	Werner	South London and Maudsley NHS Foundation Trust
Suki	Westmore	Sussex Oakleaf
Theresa	Weston	Dorset HealthCare University NHS Foundation Trust
Simon	Whalley	Self-Employed
Oliver	White	Southern Health NHS Foundation Trust
David	Whitty	Dorset HealthCare University NHS Foundation Trust
Sarah	Williams	Bournemouth University
Jo	Wiltshire	Dorset HealthCare University NHS Foundation Trust
Peter	Wolfensberger	Integrierte Psychiatrie Winterthur - Z³rcher Unterland
Sarah	Wood	Avon & Wiltshire Partnership NHS Trust
Marie	Woodhouse	Southampton Council
Pauline	Wooltorton	Dorset HealthCare University NHS Foundation Trust

Welcome

It gives us, the organising committee, great pleasure to welcome you to the second conference organised by the University Department of Mental Health, a co-operative alliance between the Dorset HealthCare University NHS Foundation Trust and the School of Health and Social Care, Bournemouth University.

Entitled "Engagement in life: promoting wellbeing and mental health", the conference celebrates and communicates innovative, Recovery-focused service development, training and research, within the context of mental health care, nationally.

We are delighted to be able to welcome Kevan Jones, MP, Rachel Perkins, OBE and Prof Geoff Shepherd as keynote speakers. In addition, an interesting and wide-ranging programme of concurrent sessions has been chosen from a 'Call for Recovery-focused Papers' that prompted an excellent response. We also welcome a number of key individuals, who will be introducing the morning and afternoon sessions, and chairing the concurrent sessions.

Finally, we would like to express our sincere thanks and gratitude to those who have been working behind the scenes to make this event such a success. John and Christine Dunkley of Grayrock Ltd, Kim Meldrum, Mary-Ann Robertson, Clive Andrews, Andy Mercer, Jo Downey, Rebecca Oliver, James Donald, Emma Matthews and all those involved in catering are worthy of our gratitude.

Our conference is dedicated to the memory of Prof Fran Biley, who sadly died in November, 2012. Fran was committed to the values of Recovery and played a key role in the success of our 2011 conference.

We are confident that this will be a lively and inspiring event and hope you enjoy it!

Prof Sue Clarke,

Director of the University Department of Mental Health,

Conference Organising Committee

Conference Schedule

08.00   Registration

09.00   Welcome and Housekeeping

09.10   1st Keynote – Rachel Perkins

09.40   Move to rooms

09.50   Break-out Session 1 – See over page for details

10.50   Coffee

11.10   Break-out Session 2 – See over page for details

12.10   Lunch

13.10   2nd Keynote – Kevan Jones

13.40   Move to rooms

13.50   Break-out Session 3 – See over page for details

14.50   Tea

15.10   Break-out Session 4 – See over page for details

15.50   Move to rooms

16.00   3rd Keynote – Geoff Shepherd

16.30   Thank-you & goodbye

Schedule for Break-Out Sessions

	Service User Experience	Focus on Intervention	Service Delivery & Evaluation	Specialist Settings	Forensic Settings	Workshops
	Marconi Lecture Theatre	Room K101	Room K103	Room PG10	Room KG03	Room PG22
09:50	**Angela Warren** The case for Self-harm vs. Alternatives for affect regulation: One person's journey	**John Chilton/Margaret Parrish** Preliminary Findings from a recovery-based psycho-educational group programme for adults with dual diagnosis	**James Barton/Becky Aldridge** Changing relationships: co-production and shared decision making within mental health services in Dorset	**Elise Leclerc** 16-25: Innovative approaches to supporting the mental health of young adults	**Jackie Preston** Shared decision making in a secure forensic mental health service for young people	**Geoff Shepherd/ Jed Boardman** Measuring Recovery Outcomes - are they value for money?
10:10	**Fran Walsh** Mental Health Service Users' Perceptions of Involvement and Recovery. A qualitative study.	**Louise McCusker** From hunting pathology to exploring recovery; changing stories in a Step 4 brief intervention service	**Helen Payne** The Embedment of the Medically Unexplained Symptoms Clinic (MUS) in Primary Care	**Claire Arthern** Personal recovery from mental health problems in young people; a professional perspective	**Jan Hutchinson** Supported Employment using individual placement and support for ex-prisoners with Mental Health problems	
10:30	**Karen Machin** Advancing Peer Support: Pathways to Progression	**Sally Branch** Coaching for Wellness in an Assertive Outreach Team: moving from hope to action plans	**Phil Morgan** "Walking the Walk": how NHS staff's own experience of trauma can shape recovery orientated culture	**Jenny Palmer** How outcomes based commissioning can improve value for people with mental health needs	**Jenny Barnes** The challenges and successes of a recovery group in forensic services	
11:10	**Donna Barrowman** Wellness Recovery Action Plan - let's unWRAP the potential	**Adam Pickles** De-centering professional power and expertise; contributions of narrative therapy to journeys to recovery	**Peter Wolfensberger** Recovery orientated mental health nursing; a pilot intervention study	**Mat Rawsthorne** Coping with Transition from CAMHS to AMH services - how peer support workers are helping young people bridge the gaps	**Celia Taylor** Recovery and Risk Management: can offenders lead the way?	**Mark Brown/ Jodi Brown** New Media, new relationships, new challenges: making social media work for mental health
11:30	**Anna Redding** What is the lived experience of being discharged from a psychiatric inpatient stay?	**Tony Stewart** Can emotional freedom techniques (EFT) be effective in the treatment of emotional conditions?	**Toni King** Is it important to measure recovery?	**Mary John** Measuring recovery for young people with depression and anxiety; dual perspective tool for use across services	**Genevieve Smyth** Engagement in life: use of occupation-focused practice for adults in secure hospitals	
11:50	**Tanya Samuels** Working Together with Service Users as peer Assessors for Service Improvement	**Emma Cosham** ACT and BPD: A Qualitative Exploration of the Process of Acceptance	**Richard Evans-Lacey** A visual representation of the recovery model	**Sarah Williams** Early Digital Intervention for Eating Disorders: The DIME and EDDGE projects	**Lisa Gale/Andy Mercer/Phil Morgan/Sue Clarke** "No Force First": how do Ward Managers review aspiration to Zero Restraint?	
13:50	**David O'Loughlin** There & Back Again! How two people implemented & built on acquired skills learnt from 'The Living with Bipolar Disorder Course' to re-engage in life	**Katrina Lahmann** Comfort Zone: One Step Beyond: Dramatherapy as a drug and alcohol treatment and recovery intervention	**Inger Kari Nerheim** How do we lead a recovery based service? Transformation or incremental steps? A leader's workshop	**James Cook** A Holistic Multi-Disciplinary Group Approach to Supporting Flexible Eating in Young People with LD	**Kate Law/Amanda Tidman** Making links: using recovery approaches to reintegrate the community and the secure environment	**Julie Repper/ Emma Watson** Developing Peer Support Workers
14:10	**Simon Whalley** Making sense of the stigma of psychological help-seeking; an interpretative phenomenological analysis	**Sam Dench/Sue Clarke** Evaluation of group-based ACT for family carers of people with Dementia	**Sarah Bateup** Successfully integrating live synchronous, internet based text, CBT into Step 3 IAPT services	**Hannah Kiddle** Developing dementia services for people with LD	**Ian Merrick** How a Patient and Staff Band in a High Secure Hospital illustrated Social Inclusion and Recovery	
14:30	**Andy Mercer/James Palfreman-Kay** It's time to talk: three short films about personal recovery from mental health issues	**Georgina Taylor/Sue Clarke** Understanding Compassionate Care in Mental Health Care Workers	**Bridey Monger** The Individual Recovery Outcomes Counter (I.ROC): measuring personal recovery outcomes in mental health services.	**Jon Bryant** Converting a Legal Tenancy Agreement into a format people with LD can understand	**Peter Crascall** Making recovery a reality in secure settings - piloting the 'secure star'	
15:10	**Naomi Mwasambili** Social Innovation in Mental Health Care for Black, Asian and Minority Ethnic Communities	**Jennifer Stickney** Working together group - the evidence behind the practice	**Phil Morgan** What was the experience of students and trainers in Recovery Education Centre Pilot Term?	**Kate Chapman** Using a psycho-social bio approach with young people experiencing psychosis		**Andy Bradley** Compassion
15:30	**Karen Newbigging** The Right to be heard; review of the quality of mental health advocacy in England	**Corrine Maskell** The 'Tree of Life' Recovery group in a CMHT in City and Hackney	**Sarah Wood** Partnership working as a way of creating an environment which supports people to re-engage in life			

KEYNOTE SPEAKERS

Rachel Perkins
BA, MPhil (Clinical Psychology), PhD, OBE

Formerly Director of Quality Assurance and User Experience at South West London and St. George's Mental Health NHS Trust, Rachel Perkins is now:

- Chair of Equality 2025 (the UK cross Government strategic advisory committee on issues relating to disabled people hosted by the Department of Work and Pensions)

- A senior consultant with the 'Implementing Recovery through Organisational Change' project team (a programme to help organizations to develop more recovery-focused practice commissioned by the English Department of Health and delivered by a partnership between the NHS Confederation and Centre for Mental Health).

- A member of the English Mental Health Strategy Ministerial Advisory Group.

- Co-chair of the English Ministerial Working Group on Equalities in Mental Health.

- External advisory member of the UK Government Inter Ministerial Group on Disability Employment.

She lives and works with a long term mental health condition and is a member of National Mind External Relations Committee. In 2010 she was voted Mind Champion of the Year and awarded an OBE for services to mental health.

In 2009 she was commissioned by the Secretary of State for Work and Pensions to lead an independent review into how Government might better support people with mental health problems to gain work and prosper in employment. (*Realising ambitions: Better*

KEYNOTE SPEAKERS

employment support for people with a mental health condition, DWP, December 2009). She has written and spoken widely about recovery and social inclusion for people with mental health conditions, set up the first English Recovery College and has pioneered the UK development of programmes to help people with mental health difficulties to access employment based on the 'Individual Placement with Support' approach, including one designed to increase employment opportunities within mental health services for people who have themselves experienced mental health problems. She has provided training and consultancy nationally and internationally, most recently in Australia, New Zealand, Norway, Denmark and the Republic of Ireland. The employment programmes she developed have been cited as an example of good practice by Zero Project 2013 International Study On The Implementation of the UN Convention on The Rights of Persons with Disabilities. Her latest book, written with Julie Repper, is *Social Inclusion and Recovery: A Model for Mental Health Practice* (2003, Balliere Tindall) and she has written briefing papers on Recovery Colleges and Personalisation and Recovery (Centre for Mental Health/ImROC, 2012).

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Kevan Jones
Labour MP
North Durham

Born in Nottinghamshire in 1964, son of a miner, he went to comprehensive school in Worksop and graduated in government and public policy at Newcastle Polytechnic and put down strong roots in the North East.

Kevan was parliamentary assistant to Nick Brown MP for four years, then political officer for the GMB, rising to be regional organiser and finally senior national organiser in 1999. During his time at the GMB Kevan led the union's campaign for compensation for the industrial victims of asbestos. He helped to re-establish the Northern Region Labour Party after its unpopular forced merger with Yorkshire, and chaired it for two years. During the 1997 General Election Kevan was campaign co-ordinator in Stockton South, when Labour regained the seat with a massive swing.

Between 1990 and 2001 Kevan served as a councillor on Newcastle City Council, Cabinet member for development, Chief Whip and committee chairman on development and transport and public health.

In 2001 Kevan was elected Member of Parliament for North Durham. During his first parliament he served as a member of the Defence Select Committee and also succeeded in getting his own Private Member's Bill on to the statute book, to prevent big stores from opening on Christmas Day.

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Kevan also campaigned on behalf of people who had had coal health compensation deducted by unscrupulous claims handlers. This led the Government to introduce the Compensation Bill in 2006, which will regulate claims handling firms. After the 2005 General Election Kevan was elected by his fellow Labour MPs to the Labour Party Parliamentary Committee, and was re-appointed to serve as a member of the Defence Select Committee and sat on the Armed Forces Bill Select Committee in 2006. From October 2008 until May 2010, Kevan served as Parliamentary Under Secretary of State for Defence, and Minister for Veterans. He is currently Shadow Defence Minister for the Armed Forces.

He has chaired All-Party Groups on Cardiac Risk in the Young, the United Arab Emirates, currently serving as Co-Vice Chair of that group. He is also currently Chair of the All-Party Coeliac Group. Kevan's main policy interests are regeneration, defence and industrial law.

In October 2010, Kevan was appointed as a Commonwealth War Graves Commissioner.

Patron of ME North East

President of Chester-le-Street MIND

Patron of Chester-le-Street & District Voluntary Welfare Committee

Hon. Vice-President of Tanfield Association May 2006

Patron of Stanley Women's Centre 2012

Director of Prince Bishops Community Bank, Stanley 2012

Prof Geoff Shepherd

Professor Geoff Shepherd trained originally as a clinical psychologist. He has worked most of his career in the NHS as a practitioner, manager and researcher. His last full-time job (2002 -2007) was as '*Director of Partnerships and Service Development*' for Cambridgeshire and Peterborough NHS Foundation Trust (CPFT).

He is currently employed part-time at the Centre for Mental Health (CMH) leading a national programme aimed at helping local services to support the recovery journeys of those using them ('ImROC'). This is part of the Department of Health's implementation plan for the mental health outcomes strategy '*No Health without Mental Health*'. He is a regular speaker at national and international conferences.

Abstracts – Breakout Session 1

Service User Experience

The case for self-harm vs. alternatives for affect regulation: one person's journey

Angela Warren (Bournemouth University)

Abstract

Evidence from research suggests that one of the main functions of self-harm is the regulation of negative affect. It can be argued that an increase in positive affect, i.e. feeling calm, relieved, relaxed, following an episode of self-harm, serves to reinforce the behaviour and increase the likelihood of lifetime duration. Though this behaviour may be deemed by some as counter intuitive; even repulsive, many who self-harm report that, for them, it is an alternative to suicide. With such positive reinforcers, one could ask 'What are the alternatives for affect regulation that provide the same outcome?' if, indeed, there are any.

DBT (Dialectical Behaviour Therapy) is one approach that has reported some success in reducing self-harm and providing other ways to regulate emotion, particularly in patients with Borderline Personality Disorder. One of the main dialectics that patients face in DBT is the desire to 'stay the same' as it is familiar and safe, while understanding that the therapy is about change

Through a personal case study, this presentation will explore the experience of 30 years of self-harm: the reasons, functions and the devastating impact on quality of life. It will identify the initial ambivalence to change; describe the perilous journey of DBT and conclude with how a genuine re-engagement with life was achieved.

Mental health service users' perceptions of involvement and recovery: a qualitative study

Fran Walsh (University of Nottingham)

Abstract

Over the last decade the importance of service user involvement (SUI) and the incorporation of the recovery approach have become embedded in policy relating to service provision, both at a local and national level. Despite this, there has been no previous research focusing specifically on the impact that involvement might have on recovery or how service users construct *how* or indeed *if* the two are related. This qualitative study sought to explore how

people: engaged in service user involvement initiatives; perceive involvement and recovery; whether involvement related to their recovery process and, if so, in what particular ways.

Nine semi-structured interviews were undertaken with participants who self-defined as having current or previous mental health problems and who were engaged in service user involvement initiatives. An exploratory qualitative method, social constructionist grounded theory, was adopted to analyse the interviews.

Participants identified explicit links between their own experiences of SUI and recovery. These links represented a connection between the characteristics perceived to be inherent to involvement and their personal definitions of recovery. However these largely positive links were in contrast to their experiences of an absence of either involvement in their own treatment or the promotion of recovery principles within services.

The core of the tentative grounded theory constructed suggests that individuals found in involvement elements which were concordant with and supported their own definitions of recovery and which were not apparent in their experiences as patients. This highlights the value of involvement in supporting recovery and indicates the value of promoting meaningful involvement across the spectrum of service user experience.

Advancing peer support: pathways to progression

Karen Machin, Mat Rawsthorne (Institute of Mental Health, Nottingham)

Abstract

National policy initiatives are fast ensuring that peer support is becoming integral to mental health service provision. The Institute of Mental Health, with its partners, has been at the forefront of this movement, having established the first nationally accredited, peer support training module. We are supporting a range of organisations to develop peer support roles within their services and to implement peer working.

Through our conversations, across the country and internationally, we are developing a unique awareness of the challenges for potential peer support workers as well as organisations.

For this presentation, we will refer to the feedback from our training which has now been delivered to over 300 individuals. We will draw on anecdotal stories to reveal the positive benefits of peer support working, as well as some of the challenges to both individual well-being and organisational implementation. We draw on these themes to offer a proposal for future developments.

Focus on Intervention

Preliminary findings from a recovery-based psycho-educational group programme for adults with dual diagnosis

John Chilton (2Gether NHS Gloucester), Margarete Parrish (Bournemouth University)

Abstract

Our presentation addresses some of the benefits of a 10-week group intervention provided to meet the complex needs of adults with dual diagnoses (Serious Mental Illness and co-existing Substance-related disorders) over an 18-month period. Using a recovery-based approach, group work was one part of an on-going study to examine the treatment needs and the effectiveness of services for adults with complex needs.

Participants included adults with a wide range of mental health conditions, lifestyles, and varied drugs of choice. Four standardised screening instruments were administered to participants as pre- and post-measures of their general mental health. The measures addressed psychiatric symptoms including psychoses, anxiety and depression, as well as substance usage and overall mental well-being/quality of life.

Group sessions were psycho-educational, and included discussions of relevant harm-reduction strategies, realistic goal-setting, affirmation work, as well as finding ways to acknowledge and endorse incremental changes among group members. Participants consistently noted the importance of the development of trust and hopefulness amongst group members. The group's capacity to provide a safe environment for intimate discussions and disclosures featured prominently in participants' feedback. The role played by trauma was a frequent point of discussion. By integrating mental health and substance-use services, participants were provided consistent and supportive means of achieving positive change without the often-cited difficulties of navigating two different and complicated bureaucracies.

Recovery principles were applied in ways that emphasised autonomy and wellness as defined by the individual participants, rather than the mental health establishment. The development of therapeutic relationships among group members as well as with those facilitating group sessions will be discussed. Factors linked with high retention rates, improved mental health symptoms and decreased substance usage will also be discussed. Participants described their experiences as "life-altering". Measurable changes following the intervention appear to endorse the recovery-based approach.

From hunting pathology to exploring recovery: changing stories in a Step 4 brief intervention service

Louise McCusker (Southern Health NHS Foundation Trust)

Abstract

Within the changing NHS context, it can be a challenge to meaningfully utilise recovery approaches within a system that seems increasingly focused on defining and measuring outcomes (DOH, 2010). This presentation describes a Step 4 recovery oriented brief-intervention pilot project.

In the search for a model compatible with recovery, it seemed that social constructionist therapies offered a philosophical coherence (Walker, 2006). Roe and Lysaker (2012) argued that the development of a personal narrative is a crucial and facilitative aspect of recovery. Based on this research, the pilot project was modelled around narrative therapy approaches.

The development of the pilot was also influenced by Jones et al.'s (1997) brief-intervention model based on social constructionist ideas. They suggested that the approach, which utilised a reflecting team model of client consultation, enabled practitioners to move away from the expert position and instead collaboratively explore clients' experiences. This shift from expert to collaborative partner is emphasised in recovery approaches (Borg & Kristiansen, 2004) and seemed integral to ensuring that the pilot model was genuinely recovery focused.

Drawing from Jones et al. (1997), a pilot project was developed to offer a recovery informed brief-intervention therapy model. The approach involved two practitioners meeting with individuals to explore the difficulties that led them to seek help. Specific narrative techniques were utilised such as externalising the problem, exploring forgotten stories and highlighting strengths (White & Epston, 1990). As practitioners, the approach has enabled us to leave behind disease-based models which we felt encouraged us to hunt and label pathology. Instead, we have been able to explore each person's unique story. Service users reported that the approach offers relevant and non-pathologising support. Whilst the evaluation is on-going, we are hopeful that the pilot offers a theoretically coherent and practically useful way of working in a recovery oriented manner.

Coaching for wellness in an Assertive Outreach Team: moving from hope to action plans

Sally Branch (Dorset HealthCare University NHS Foundation Trust)

Abstract

The importance to recovery of addressing mental health as well as mental illness is becoming more widely recognised (Slade 2010), and life coaching is being recognised as a valuable, recovery-focused approach in mental 'health' services. (Bora et al 2010) This presentation compares and contrasts 'wellness' and 'illness' approaches in mental health and argues that coaching is one method of facilitating behaviour change that promotes wellness - for staff as well as clients! Drawing on material from her recently developed Recovery Coaching Skills training course, the presenter will introduce the 'building blocks of coaching', consisting of hope, values, strengths, goals and action plans. Understanding the role of each of these elements helps to explain why attempting to set goals too early can be counter-productive.

There will be a brief explanation of relevant theory and research evidence, including positive psychology and self-determination theory.

References

* Bora R, Leaning S, Moores A & Roberts G (2010) Life coaching for mental health recovery: the emerging practice of recovery coaching. *Advances in psychiatric treatme*nt (16) 459-467

* Slade M (2010) Mental illness and well-being: the central importance of positive psychology and recovery approaches *BMC Health Services Research* 10:26 http://www.biomedcentral.com/1472-6963/10/26

The author is an occupational therapist and coach with a passion for enabling true wellness rather than just an absence of illness. She has developed and run a training course teaching Recovery Coaching Skills to clients, staff and carers and is currently working part time in an Assertive Outreach Team, where she combines positive psychology, occupational therapy and coaching approaches.

Service Delivery & Evaluation

Changing relationships: co-production and shared decision-making within mental health services in Dorset

James Barton (Dorset HealthCare University NHS Foundation Trust)

Becky Aldridge (Dorset Mental Health Forum)

Abstract

The Department of Health's agenda regarding public health is to: "Transform public health and create, for the first time, a true 'wellness' service to meet today's public health challenge".

The aim of this paper presentation has this objective in mind and will provide a critical debate of: "Where is the Health and Wellbeing in Dual Diagnosis?"

Individuals with dual diagnosis pose a significant challenge for health and social care services. People with a dual diagnosis have higher levels of morbidity and mortality often engaging in the main behaviours that are the concern for Health and Wellbeing bodies. In a recent discussion paper from the Centre for Mental Health, DrugScope and UK Drug Policy Commission, they acknowledged that some progress has been made in relation to the holistic care of people with dual diagnosis, but support for these individuals is still frequently inadequate (Centre for Mental Health 2010).

This paper presentation will argue that with the introduction of a recovery agenda in substance misuse and mental health represents both an opportunity and a threat to people with a dual diagnosis. Within the context of diminishing resources and the arrival of new commissioning structures an important question is raised regarding how these changes will impact upon this vulnerable at-risk group. The presentation will consider issues of "responsibility" and "double discrimination" and how they relate to practice.

Individuals with dual diagnosis are a vulnerable at risk group who pose many challenges to services. We argue that their health and well-being are under threat due to their complexity and from the changing dynamics in services and policy directives.

The embedment of the medically unexplained symptoms clinic (MUS) in primary care

Prof Helen Payne (Hertfordshire University)

Susan Brooks (Pathways2wellbeing Ltd)

Abstract

This presentation will address the concept of MUS, mental health and wellbeing and the nature of the problem to which The MUS Clinic is the solution. This population are high health utilizers costing NHS England 18 billion per year. 10% to 15% of 14 common physical symptoms seen in primary care are found to be caused by an organic illness. Such physical symptoms of unknown biological aetiology are referred to in the literature as "medically unexplained symptoms" (Katon and Walker 1998).

There is no pathway for treatment especially for the majority who are resistant to psychological therapies. The embedment of innovative research using The BodyMInd Approach (TBMA)™ is via a University of Hertfordshire spin-out company pathways2wellbeing. The MUS Clinic in Hertfordshire Primary Care will be described together with outcomes for service users and the NHS. The recovery model is central to the approach delivered which supports the wellbeing of service users through 12 months of contact.

The characteristics of people with MUS, how to recognize them, who may be suitable and the criteria for referral are illustrated. The benefits including reduced health visits, medication and increased activity levels for patients are outlined. The process of phase 1 and 2 is tracked from referral through to discharge with a case study as an example.

Service user comments include 'Relevant techniques, communication skills, overall wellbeing, friendly atmosphere'; 'It was pointed out that I need to think more of myself rather than being involved in other people's problems'; 'I learned new strategies for coping with my symptoms'; 'It gives me hope'; A commissioner recently endorsed the service: 'They have the benefit of having national leading expertise in the treatment of MUS and have proven themselves as extremely capable of running learning/treatment groups for patients and training staff'.

"Walking the walk": how NHS staff's own experience of trauma can shape recovery orientated culture

Phil Morgan (Dorset HealthCare University NHS Foundation Trust)

Abstract

Recovery orientated practice requires NHS Staff to re-evaluate how they perform in their roles and how they relate to the people who access their services (SCMH 2010). Central to this is exploring the role of 'lived experience' and how the staff's own experience of trauma can be utilised to support the recovery journey of individuals and the organisation.

Dorset HealthCare have undertaken two local service reviews, one exploring a survey of the MH Directorate exploring lived experience of staff and 'them and us' culture. 33%, response rate 52% lived experience mental health problems. People were asked what the organisation can do to support staff wellbeing. The second is a discussion document which was developed out of three focus groups consisting of representative from the Health Team, Service Users and Professional Bodies. This document explores how sharing our lived experiences of trauma can enhance a recovery orientated culture and what would need to be in place for this to be safely explored. This presentation will pull these two pieces of work together and explore how services could change and what the potential impact would be.

Specialist Settings

16-25: innovative approaches to supporting the mental health of young adults

Elise Leclerc (Mental Health Foundation/Paul Hamlyn Foundation Right Here Initiative)

Abstract

Introduction: Right Here is a unique, five-year collaboration between Paul Hamlyn Foundation and the Mental Health Foundation to develop effective new approaches to improving the mental health and well-being of 16 - 25 year olds, a much neglected group.

Approach: Since 2009 Right Here has been working with four voluntary sector-led partnerships in Brighton and Hove, Fermanagh, Newham, and Sheffield, where young adults and professionals (youth workers and mental health professionals) have worked together to design, deliver, commission and evaluate a range of health promoting, therapeutic and resilience- building activities.

The projects are changing how Right Here partners and other organisations work with young adults, providing mental health awareness and other training to front line workers, and are

consistently raising the bar in terms of young adult's participation. They are also influencing practice and policy more widely. For example, in Right Here Brighton and Hove, young volunteers and staff, supported by the Clinical Commissioning Group, have been working with GPs to improve how they respond to young adult's emotional health and wellbeing needs.

To date the programme has worked with over 2,000 young adults, and outcomes are being extensively evaluated with a full report expected in 2014.

In 2011, Right Here, with Comic Relief and Nominee Trust began developing a range of new digital products to support young adults' mental health, as part of the Innovation Labs initiative. Out of this process emerged 'Mini Me', a recovery-focused App currently being developed by FACT with Mersey Care NHS Trust in Liverpool.

Emerging results: The initiative is being evaluated in two ways:

1. Process evaluation carried out by the Institute for Voluntary Action Research (IVAR)
2. Impact evaluation carried out by the Tavistock Institute of Human Relations and the Institute for Voluntary Action Research (IVAR)

Impact on service-users' mental health: The participatory approach and user-involvement in designing services jointly with professionals has proved a strong factor in helping young adults' mental health. This has been reflected at local and national level, with the involvement of service-users in designing and steering the Right Here initiative being reported as extremely empowering by young adults. Although the final evaluation is not due until end 2014, emerging findings from the impact evaluation reveal that these interventions have significantly improved young people's social, psychological and emotional well-being, and helped service-users on their path to recovery.

Results from the co-design Innovation Labs process: Following a seven-month co-design process with over 80 young adults through face-to-face and online consultation, 8 ideas were selected to be developed through a grants programme. One of those called Mini Me is 'a personal interactive recovery guide using information inputted by the user on their activity, environment and mood with the ability to issue an alert to friends and family of the need of support'. The Mini Me co-design process and impact on users' mental health once developed are being evaluated externally.

Practice and policy implications/conclusion: Drawing on the evaluation and the views of the young people who have been involved, future youth mental health services could include the following key features:

- Understanding of mental health and skills in youth counselling and engagement must be built into the work of all generic, non-specialist practitioners, such as GPs and youth workers
- Removing the barrier between primary mental and physical health services and developing a range of holistic interventions to enable young people to flourish in all aspects of their lives
- Youth-centred, community based services must be developed that allow young people a primary role in design and an influence over the when and where of delivery.

Services should be commissioned which do not discriminate on the basis of age, and young people should be offered choice and control of their mental health care.

Personal recovery from mental health problems in young people: a professional perspective

Dr Claire Arthern (Sussex Partnership NHS Foundation Trust)

Mary John (University of Surrey)

Abstract

Background: The philosophy embedded within person-centred recovery has been adopted by health care professionals providing interventions for adults with severe and enduring mental health concerns. More recently there has been an NHS confederation directive that this approach should be extended to - clients across the life span. There is little open discussion within Child and Adolescent Mental Health Services (CAMHS) as to relevance, given the centrality of parental involvement and associated developmental issues present.

Aims: To develop an understanding of how CAMHS professionals conceptualise recovery in children and adolescents.

Method: A qualitative study, utilising grounded theory, was undertaken to explore CAMHS professionals' understanding of person-centred recovery. Twelve participants were recruited from multi-disciplinary CAMHS teams in Southern England. Participants had a range of experience in CAMHS All core professional disciplines were recruited.

Results: The theoretical model to emerge from the data suggests that the process of change for families was focused within three areas - the 'Child Experiencing Change', 'Parents Experiencing Change', and 'The Family Unit as a Whole Experiencing Change'. The experience of change for the family unit is qualitatively different to simply the experience of young people *in addition* to the experience for parents. This change for the family unit surrounds a process whereby parents make changes to their own wellbeing, attitudes and parenting which impact on young people with a varying degree of directness. The changes

that the young people then make consist first of 'Exploring Self' and 'Changing Outlook', which precipitate 'Having a Better Quality of Life', 'Changing Physically', 'Expressing and Communicating Differently' and 'Functioning Normally'. Although the experiences for the child, parents and family unit were distinct from each other, they were intimately related, and reciprocal. There was little evidence that changes were sequential and also that the process was linear or had an 'endpoint'.

How outcomes based commissioning can improve value for people with mental health needs

Jenny Palmer, Dr Emma Stanton (Beacon Health Strategies, UK)

Abstract

Objective: People with mental health problems have multiple mental health, physical health and social care needs, but commissioning is fragmented as commissioners contract separately with providers. Payment mechanisms include any combination of payment for activity, a block payment and payments for specific indicators (e.g., CQUINs). Multiple providers may be involved in any individual's care but are not coordinated in a meaningful way. Contracts are not based on achieving patient focused outcomes but rather process indicators including length of stay and time from referral to appointment. There is an opportunity for commissioners to focus on redesigning contracts and incentivizing providers to deliver the outcomes that matter most to people with mental health needs. There are a number of key steps that commissioners need to take to move to outcomes based commissioning contracts. Oxfordshire Clinical Commissioning Group (CCG) recently started on the journey to move to outcomes based contracts to improve the mental health care of its local population.

Process: There are three key stages to move to an outcomes based approach to commissioning, which Oxfordshire CCG is following.

The first stage is to undertake a feasibility study to determine spend and activity on mental health services, including social and acute care if possible. The population cohort should be determined. Oxfordshire CCG separated the population by HONOS-PbR super cluster; non-psychosis (anxiety and depression), psychosis and cognitive impairment (dementia) and apportioned spend, activity and contracts to each of these super clusters. In this stage commissioners should start the engagement with local stakeholders to determine what outcomes matter most to the local population with mental health needs. The second stage is to develop the contracting model, test the financial assumptions and develop the outcomes, which include sensitivity analysis based on the defined patient cohorts. Oxfordshire developed outcomes based on the Porter (2011) three tiered hierarchy model, which is

increasingly used globally as a standardized approach to developing outcomes. Existing data feeds within provider organisations are then identified, along with new data feeds that need to be developed. Outcomes will typically cross health, social care and third sector providers. To determine the contracting model the current market needs to be analysed and open book accounting from the current provider market is needed to determine true activity and cost. The third stage is to transition to the new contracting model, which may involve a tendering process for all or part of the new contracts. Oxfordshire CCG found that certain patient cohorts lend themselves to competitive tender more than others.

Current Progress: The work undertaken by Oxfordshire CCG is ahead of the curve of most CCGs who commission mental health services. They have shown that it is possible to think about mental health contracts differently and boldly, and focus on the outcomes that matter to patients. Oxfordshire CCG has identified the service their patients with mental health needs receive at a more granular level than ever before. This includes the current level of activity, spend, housing and employment status of the HONOS PbR super cluster cohorts. Service users have also defined the outcomes that matter most to them, which go far beyond the walls of the acute hospital setting. Oxfordshire CCG is now undertaking the full work up to move to a possible tendering process.

Next Steps: Oxfordshire CCG is an example of a forward thinking commissioner that has prioritized mental health as an area to make tangible changes for the benefit of patients. They show promise that by moving to new models of contracting it is possible to improve mental health outcomes as well as reducing the cost of care.

Forensic Settings

Shared decision-making in a secure forensic mental health service for young people

Dr Jackie Preston, Helen Gibson, Nicole Harrod (Southern Health NHS Foundation Trust)

Abstract

Closing the Gap: Shared Decision Making in CAMHS was a 2 year quality improvement initiative funded by the Health Foundation in collaboration with Young Minds, CAMHS Evidence Based Practice Unit, and CAMHS Outcome Research Consortium. The aim is to transform the CAMHS experience from service user passivity to a situation in which treatment is genuinely agreed in collaboration between young people and practitioners. Bluebird House was selected as one of four sites for the project.

The challenge to implementing the project in an adolescent forensic setting was to find ways to meaningfully, yet safely, share decisions with young people who are residing in a setting

where they have reduced opportunities for choice and control. Successes in shared decision making with young people and resulting changes to clinical practice include creating a young person's portfolio, completing joint risk assessments and co-creating care plans. Video Interaction Guidance and Graphic Facilitation are some of the tools used to support the process. Qualitative feedback from young people and staff about the impact of the project and additional supporting clinical data will be presented.

Supported employment using individual placement and support for ex-prisoners with mental health problems

Jan Hutchinson (Centre for Mental Health)

Abstract

The effectiveness of the Individual Placement and Support (IPS) approach has a robust evidence-base which was developed in secondary mental health care settings. Ex-offenders leaving prison are a group who experience much lower levels of employment than the general population and have access to very few sources of support.

Prisoner also have notably high levels of mental ill-heath (some researchers have estimated that 70% of prisoners have at least one diagnosable mental health condition, and, when mental health, alcohol and drug addiction issues are all included, the number of prisoners with at least one problem is possibly as high as 90%).

Centre for Mental Health working with Enable, the specialist Employment Service of Shropshire Council, and The Institute for Mental Health (IMH), University of Nottingham, is piloting the use of IPS with men and women leaving three prisons in the West Midlands.

Trained IPS Employment Specialists will initially integrate a personalised supported employment intervention with the work of the Mental Health in-reach teams, part of South Staffordshire and Shropshire NHS Foundation Trust, engaging with prisoners just before release and continuing the support 'through the gate', working intensively with them in the community to seek job opportunities and develop paid employment placements with local employers.

Enable is one of the UK Centres of Excellence in IPS and will deliver a service with high fidelity to the IPS model. This innovative approach will be studied by a researcher from IMH. The presentation will describe the challenges faced and how this approach to supported employment could provide an effective solution.

The challenges and successes of a recovery group in forensic services

Jenny Barnes (Southern Health NHS Foundation Trust)

Abstract

How can we involve service users more in their recovery and also increase their hours of structured activity? The talk will describe a recovery group, run at a low-secure forensic mental health unit, which helps to meet the goals of greater engagement in recovery and provision of 25 hours of structured activity per week, as set by The Quality Network for Forensic Mental Health (2010).

The group is based on the principles of recovery, and each session has a different topic based upon the Recovery Star (MHPF & Triangle Consulting, 2011). A facilitator of the group will reflect on the challenges of promoting recovery in a low-secure environment, and will also discuss how to manage difficulties of running the group and which topics and approaches have been more successful.

Abstracts – Breakout Session 2

Service User Experience

Wellness recovery action plan: let's unWRAP the potential

Donna Barrowman (Peer Support Network)

Abstract

Wellness Recovery Action Planning (WRAP) is a self-management tool. It is usually facilitated in a group setting and is always led by individuals with lived experience of managing mental health challenges. WRAP supports and encourages people to take personal responsibility for their recovery and for maintaining their own levels of wellness. It also encourages individuals to become empowered by encouraging them to become active in self-advocating for their needs and wishes resulting in them actively taking control of their recovery.

From 65 individuals who have participated in the WRAP workshops we have facilitated – over 90% feel more hopeful and feel that they have the ability to be more in control of their own lives after completing the 2 day workshop. Many professionals have come along to see how WRAP could benefit their clients and been delighted to find they have a tool which they can use for their own wellbeing. One professional commented "I came as a professional to see how WRAP could help others – and I'm leaving with a tool I can use myself".

When asked to describe their WRAP experience common themes emerge such as hopeful, inspiring, fun and thought provoking.

Does WRAP work? Well for me it has been life changing. For many years I knew all there was to know about my illness – but that I now realise was half the problem!! My focus is now on my wellness. Each day I actively plan to stay well. I have wellness tools that I use on a daily basis to support my on-going journey through life – feeling well and living well. And yes – sometimes things happen that cause me upset – but I now have a plan in place to help me manage those difficult times. WRAP is a tool for life – and certainly for me has become a way of living life to the full.

What is the lived experience of being discharged from a psychiatric in-patient stay?

Dr Anna Redding (Southern Health NHS Foundation Trust)

Abstract

This qualitative study used semi-structured interviews and Interpretative Phenomenological Analysis (IPA) in an attempt to understand the lived experience of being discharged from psychiatric inpatient stays. Psychiatric patients encounter many difficulties post-discharge and suicide rates are high, particularly within the first three months. However, to date most research has used quantitative methods to examine these difficulties and the effectiveness of discharge interventions. Therefore, little is known about why discharge is so difficult for people with mental illness. Eight participants who had been discharged from psychiatric hospital within the last three years were interviewed to explore their experiences of discharge. Five superordinate themes emerged from the data. These are discussed along with clinical implications and suggestions for further research.

Keywords: Interpretative Phenomenological Analysis, mental illness, psychiatric discharge.

Working together with service users as peer assessors for service improvement

Tanya Samuels (Richmond Fellowship)

Abstract

Effective Service User engagement is essential to provide quality mental health Services. Richmond Fellowship developed a methodology for involving Service Users in assessment teams which can be replicated by other organisations reviewing services. Involving Service Users ensures that their perspective and experience is reflected, strengthening transparency, quality assurance and providing valuable Service User involvement opportunities.

Design/Methodology: Richmond Fellowship evaluated its approach by conducting 12 semi structured interviews and a workshop with Service User peer assessors. We also distributed questionnaires to managers in assessment teams and held a focus group with lead staff assessors. Data was analysed using thematic analysis.

The evaluation explored the strengths of the current approach, areas for improvement drawing key lessons to share with other agencies interested in replicating the approach.

Findings: Service Users require clear, accessible information about the assessment role. The preparation, time commitment, skills, expectations and approach should be communicated to ensure a clear, shared understanding of the role among staff and Service

Users. Organisations should communicate the benefits of Service User involvement at an individual and organisational level.

Service Users (including those from higher level services) can successfully contribute to reviewing services, providing support and flexibility are involved to ensure an inclusive approach. Support processes must be defined and understood by staff and Service Users.

Service Users found reviewing services interesting and rewarding. They valued learning about the processes and activities involved behind delivering services. Individuals gained valuable transferable skills and recent employment would help with future opportunities. Moreover, they valued being able to offer something to Services which had supported them. Two individuals have used the experience to pursue other research opportunities. Participants said the experience presented a personal challenge which had built their confidence and self-esteem and we are considering pathways for Service Users to continue to build on the experience and confidence which they have gained following reviews.

Focus on Intervention

De-centering professional power and expertise; contributions of narrative therapy to journeys to recovery

Adam Pickles (Dudley and Walsall Mental Health Partnership NHS)

Abstract

In this presentation Adam describes the impact of working within a narrative therapy framework (White, 2007) on the recovery stories of clients in an adult mental health community setting with multiple and complex needs with origins in abusive and oppressive acts visited upon them. He outlines some of the assumptions and subsequent practises of forms of narrative therapy and their links to a recovery philosophy which emphasises shifting power balances, sharing expertise, the value of hope to recovery journeys (Allott, 2005) and collaborative caring. Some of the practices of narrative approaches are described including 'relative influence questioning', 'externalising conversations', the 'club of life' metaphor, 'remembering' and 'witnessing practices'. Adam also speaks about the challenges for therapists and health workers who step into new territories of relationships with people they are helping where they can begin to speak about becoming different themselves through this work and that they can be touched and moved to other places in their own lives as a result of accompanying clients on their recovery journeys. Attention is paid to the questioning conversational language of this approach to therapy and the links to a liberating language of

recovery which is appreciative and resource-focused rather than problem and deficit-based and is thus enhancing rather than diminishing of people's identities.

Can emotional freedom techniques (EFT) be effective in the treatment of emotional conditions?

Prof Tony Stewart (Staffordshire University)

Abstract

Description of objectives: A service evaluation was carried out to establish the feasibility and effectiveness of Emotional Freedom Techniques (EFT) in the NHS.

Setting: A dedicated EFT service, within the NHS in the district of Sandwell, West Midlands. Referrals were accepted for any emotional condition (including physical pain), provided that clients were over 18 and not "vulnerable adults". Ethical approval was secured.

Method including assessments: Over a 13 month period, clients accessing the EFT service for a range of emotional conditions were invited to participate. Those who gave consent were included in the service evaluation. At the start and end of their treatment, clients were asked to complete the CORE10 (main outcome variable), WEMWBS, Rosenberg Self Esteem and HADS measurement scales. Clients completing their therapy were invited for a 3-month follow-up.

Results: Thirty-nine clients gave consent, and 31 completed therapy. A total of 77% were female, and 80% were White British. The mean age was 45 years (range 18-76), and mean number of sessions attended was 5 (median 4; range 2-17). The main presenting conditions were anxiety, depression and anger and clients revealed up to 4 additional issues. CORE10, Rosenberg Self-Esteem, HADS Anxiety and HADS Depression scores showed both statistically and clinically significant improvements, with statistically significant improvement for WEMWBS (all $p<0.01$). Mean CORE10 scores improved from 20.16 (moderate severe) at start to 8.71 (normal) at end (SD difference=6.81, $p<0.001$). Improvements were seen in all but one client.

Conclusions: Despite the limited sample size and other limitations, significant improvements were shown. The results support the potential of EFT as a cost-effective treatment to reduce the burden of a range of physical and psychological disorders. Further larger studies are called for, with protocols to minimise drop-outs.

ACT and BPD: A qualitative exploration of the process of acceptance

Emma Cosham (University of Surrey)

Abstract

Background: The research base for Acceptance and Commitment Therapy (ACT) has some emerging and promising findings for treating individuals borderline personality disorder (BPD) (see Clarke et al., 2012). ACT posits that acceptance and willingness to experience difficult emotions would allow one to engage with a valued life alongside such distress. Theoretically, this concept may present a particular challenge to individuals with BPD, where high levels of experiential avoidance has been found to fully mediate the relationship between BPD features and intense emotional affect (Gratz, Tull & Gunderson, 2008). This research seeks to understand if and how people diagnosed with BPD experience acceptance of intense emotions, and, using pre- and post-therapy interviews, how this may change following a pure-ACT intervention.

Method and Analysis: A phenomenological design was adopted to explore the research question. Semi-structured interviews were conducted before and after a 12-week ACT group with a homogenous sample (N=6), and Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009) was utilised to explore the process of change.

Findings: At pre-group, the analysis revealed particular difficulties in the relationship with emotions, with the participants engaging in various methods to try and cope with them. This, in turn, seemed to paradoxically intensify their very experience. Following the ACT group, five of the participants' relationship to emotions seemed to have changed considerably. Patterns of flexible, considered ways of responding to distress revealed a contrast to the pre-group narratives of extreme, uncontrollable experiences with fixed and all-or-nothing responses. Negative emotions were viewed as less dangerous and problematic, with verbatim anecdotes illustrating evidence of positive change in their lives.

Discussion: The findings and their implications are considered in the context of the existing ACT, RFT and BPD literature. Examples of the ACT processes of change in action support the clinical applicability of the model for BPD.

Service Delivery & Evaluation

Recovery orientated mental health nursing: a pilot intervention study

Peter Wolfensberger (Bournemouth University)

Abstract

Based on previous studies that have been focusing on current practices in mental health nursing and the on-going development in mental health practice towards a more recovery-oriented approach this pilot intervention study focuses on improving mental health nursing practice through providing specific training sessions for nurses and the implementation of goal-oriented care in close collaboration with service users. Results are measured within a pre- and post-test design among health professionals and service users. The presentation will contain an introduction of the study protocol, an experience report and hopefully some initial results of the study.

Keywords: intervention study, mental health nursing, recovery orientation, goal attainment, motivational interviewing.

Background/Objectives: Nursing practice in inpatient psychiatric settings often focuses on the management of the acute situation/crisis and its current symptoms as well as on the overall management of the ward. Therefore, the core focus is often on disease, problems and safety/security aspects only instead of or less on service users' personal resources and goals that are mostly related to the situation outside the hospital in his or her social environment and to symptom management and adaptation process at home.

Based on various concepts such as recovery (Slade 2009) and empowerment and on the results of previous studies (Björkdahl et al. 2010, Richter et al. 2010), a pilot intervention study was developed. The objectives of this pilot study are to implement and evaluate a nursing intervention in hospital based mental health acute wards that promotes social integration and participation of service users by using a more goal-oriented approach to nursing care. The intervention focuses on personal recovery, social inclusion, achievement of goals and the use of motivational interviewing and coaching techniques.

Methods: The study is conducted on 6 wards (4 intervention wards and 2 control wards)in two mental health clinics in Switzerland between January 2013 and March 2014 and uses a mixed method design. The quantitative data collection is based on a pre- and post-test design, using the following instruments: "Recovery Self-Assessment" [RSA] (O'Connell et al. 2005), "Stages of Recovery Instrument" [STORI] (Andresen et al. 2006) and "Goal Attainment Scale" [GAS] (Hurn et al. 2006). The intervention part of the study contains

training sessions for the nurses of the intervention wards and the implementation of the taught techniques and knowledge into daily nursing practice with systematic support of peers and experts. A total of four half-day training sessions will be provided focusing on recovery orientation, social inclusion, goal attainment, coaching and motivational interviewing. For the qualitative part of the study four focus groups with users and nursing staff will be conducted at the end of the intervention period. The intended sample size is n=60 for mental health/psychiatric nurses and n=240 for service users. In each focus group 7 participants (n=14 service users, n=14 nurses) are included. The study is supervised by an expert panel of healthcare professionals, service users and carers.

Results: The study protocol will be presented and first experiences including some methodological challenges will be reported and discussed. Additionally, if already available, a brief outline of the results of the first of three data collection periods will be presented.

Discussion: As to our knowledge nursing intervention studies in the psychiatric inpatient setting are scarce and this is probably the first study that focuses on implementation and evaluation of recovery and social inclusion techniques in the German speaking area. Evaluating nurses' mental health care is complex and difficult.

Is it important to measure recovery?

Toni King (Solent NHS Trust)

Abstract

 The drive to measure outcomes (rather than activity) is of increasing importance as services seek to ensure value for money. New emphasis on Patient Reported Outcome Measures and Patient Reported Experience Measures, serves to triangulate 'Service-reported' achievements and ensure value at an individual level. Similarly, the ability to measure the complex and unique recovery experiences of people accessing our service is desirable to service users and carers, clinicians, managers and commissioners. However, this approach has an inherent risk - the whole-scale application of a single mechanism potentially denies the uniqueness of each person's recovery. Additionally, the dearth of valid, reliable Recovery Outcome Measures (ROM) limits the meaning that can be drawn from data produced.

A pilot study to identify meaningful and practicable Recovery Outcome Measures (ROM) has been completed in an Adult Mental Health Service. The two measures identified are being introduced into day-to-day practice, in order to ensure equal emphasis on clinician reported and individually experienced recovery. The ROMs provide individual measures of progress/ lapse, and are also available for carer's and important others to complete - these provide a

rich point of exploration and engagement in understanding the individual's current experience. From this discussion, recovery-focussed care planning is undertaken.

This work focusses on Centre for Mental Health's Organisational Challenge 1: 'Changing the nature of day-to-day interactions and the quality of experience'. It is a key tool in this Trust in re-focussing the approach and values of staff. The very clear focus on tangible changes to how we work with an individual has been received with interest and enthusiasm by clinicians and doctors.

Although early into this implementation, our experience is that despite the limitations of applying a standardised measure and the data these produce, the gains from engaging staff and individual's in a meaningful recovery-focussed interaction are priceless.

A visual representation of the recovery model

Richard Evans-Lacey (Psychic Plumbing)

Abstract

This work is based on Jacobson and Greenley (2001) "What is Recovery" and other sources.

The overall concept of recovery can be difficult to grasp, particularly when it is presented in text based academic articles. This diagram summarises the journey from being lost in despair, to discovering hope, and the process of recovering meaning. At each stage of this journey it describes the role of the participant, the role of the significant others in their life, the relationship dynamic between them, and the environments in which all of this happens.

The hope is that this diagram could help staff in supporting organisations understand a theoretical context for their work and how it enables participants to transition into self-maintained recovery.

Specialist Settings

Coping with transition from CAMHS to AMH services: how peer support workers are helping young people bridge the gaps

Mat Rawsthorne (Institute of Mental Health, Nottingham)

Abstract

 This paper will present the key aims and central themes behind a training initiative for Peer Support Workers. Innovative service improvement will be showcased in respect of transition

arrangements. The presentation will also share insights into how peer support workers are helping young people to navigate the transition process.

Nationally transitions from Child and Adolescent Mental Health Services, (CAMHS) to Adult Mental Health Services, (AMHS) have been the focus of a number of research studies, (Swaran, 2009), (Pugh. K, Meir. R, 2006) all of which have identified numerous difficulties, specifically around service user experience, disengagement, thresholds for acceptance and long delays in completing transition. Joint working between the services has also been identified as an obstacle.

However, there is a new role in mental health: Peer Support Workers. NHS Trusts across England are now introducing these intentional posts for people who have had their own lived experience of distress. They support their peers by providing support based on common experiences, promote hope and walk alongside them, offering the learning of someone who has been there.

Rotherham Doncaster and South Humber NHS Foundation Trust, Children and Young People's Business Division provide child and adolescent mental health services to the population of Rotherham, Doncaster and North Lincolnshire, this includes CAMHS services for children with Learning Difficulties, (LD).

Broad agreement was found with the studies cited above. Therefore, to address this following joint consultation and data gathering, six Peer Support Workers, (PSW's) were employed and trained and more recently an additional PSW for CAMHS LD services. It was felt that the role of a PSW would improve the transition experience for young people who required continuing support from adult mental health services and enhance any outcomes for young people.

The Institute of Mental Health, (IMH) Nottingham, offers a National accredited peer worker training module for these new workers. This module provides an opportunity for experiential learning and helps support the development of skilled and informed Peer Support workers. It is delivered by two co facilitators, to include lived experience of distress as well as academic and clinical expertise. The co facilitators role model equal partnership working. Peer support workers need to develop a relationship of mutual support with the person they support, as well as the staff they work alongside.

The presentation will highlight effective collaborative working between the IMH and the host organisation and the importance of this in preparing teams and services for PSW's. The final part of the presentation will explore the training delivery model that was adopted and the co learning that occurred.

Feedback from both CAMHS and AMHS staff and also service users has been extremely positive and has supported the future use of PSW's in the service and suggested the expansion of such services in the future. Personal reflections and insights into the role of a PSW within the transition process will be shared and how this role is developing. The presentation will conclude with learning points which will be of interest across a variety of settings.

Measuring recovery for young people with depression and anxiety; dual perspective tool for use across services

Mary John, Laura Simonds, Fiona Warren (University of Surrey)

Abstract

Background: Although the recovery philosophy is integral to directives concerning mental health service provision for young people both the construct of recovery on which these are based and any related measures are currently derived from perspectives and data provided by adults with severe mental illness.   There is, as yet, no UK empirical data about recovery in children and adolescents with mental health problems and no tools to assess recovery in this group.

Aims: To develop young person- and parent- report measures of recovery.

Method: Three measures were developed from qualitative data collected from young people who were experiencing or had experienced depression or anxiety and who had been referred to specialist Child and Adult Mental Health Services in the South East of England. Measures were of: young person's self-reported recovery (Request-YP), parent's report of the young person's recovery (Request-PYP), and parent's report of their own recovery journey through their child's difficulties (Request-P). The Recovery measures were sent to 370 families engaged with specialist CAMHS services in Southern England along with measures of the commonly used Strengths and Difficulties (SDQ) *Goodman et al., 1998*) and self-esteem (RSE) (*Rosenberg, 1965*).

Results: all three measures demonstrated good internal reliability (α=.89-.95). Young people who scored in the normal range on the SDQ had significantly higher recovery scores than young people scoring in the borderline and abnormal range. Request-YP scores were positively correlated with self-esteem (r= .84). Parent report of their own recovery process was correlated with their report of their child's recovery process (r=.44). Parent reports of the child's recovery were significantly more positive for parents with children in the 'normal' than 'abnormal' range on SDQ.

Conclusions: these initial validation data suggest that the recovery measures have the potential to be used in service evaluation and clinical outcome measurement.

Early digital intervention or eating disorders: the DIME and EDDGE projects

Dr Sarah Williams (Bournemouth University)

Abstract

Background: Eating disorders (EDs) affect 1.6 million people in the UK. They can have devastating consequences on those that experience them including severe physical and psychological distress, reduced quality of life and even death. People with EDs are often ambivalent about recovery as, unlike most other psychiatric conditions, core features of EDs can be highly valued. This can lead to treatment resistance and a failure to engage with services: 87% may never seek help in the first place and nearly a third of those who are referred for specialist treatment never attend the initial assessment for treatment.

Delivering Digital Resources for Early Recognition and Intervention for Eating Disorders:

This presentation will present two innovative studies designed to engage people with EDs in treatment and therefore provide essential early recognition and early intervention.

The first is DIME, which stands for DIgital Motivation Enhancement and aims to prepare those who are referred to ED services for their assessment. Service-users will be able to use four online sessions, delivered as interactive web pages, whilst they would normally be on a waiting list for assessment. This will allow them to learn about ED treatment and empower and motivate them to make their own choices about recover. We will present the DIME intervention alongside views from service users who have used the website and discuss plans for further evaluation.

The second is EDDGE, an Early Detect and Direct intervention in the diGital Environment. The aim of EDDGE is to understand how people with EDs, their friends and families and health professionals first recognise an ED. We will present preliminary work into early detection and our plans to use this to provide easily accessible online resources to facilitate early diagnosis and intervention.

Forensic Settings

Recovery and risk management: can offenders lead the way?

Dr Celia Taylor (East London NHS Trust)

Abstract

This paper will describe service user involvement in recovery, in one of the original medium secure "Dangerous and Severe Personality Disorder" services.

Millfields Unit in North East London is a 16-bed medium secure facility for personality-disordered offenders who have committed offences such as homicide, rape and armed robbery, and are thought to present an on-going high risk to the public. The treatment model is that of a modified therapeutic community (TC), in which the traditional TC elements of community meetings and small group psychotherapy are combined with group and individual offending behaviour work. Perhaps the most important focus of the work is on developing the patients' understanding and management of their own risk, through utilising the therapeutic spaces to promote thinking over mindless action, and through facilitating peer group feedback as one of the primary therapeutic tools. This talk will outline innovative forms of patient involvement in the following areas:

- Offence disclosure
- Discovering why difficult relationships are so difficult
- Structured risk assessments such as the HCR-20
- Self and peer reports for CPA Review Meetings
- Patients feeding back their clinical formulation in the community meeting for discussion with their peers
- A patient-led ward round
- Applications to the Ministry of Justice for Community Leave

The paper will also discuss how staff can be supported in this challenging work, and the important information that is to be gathered from apparently destructive processes such as splitting and the testing of boundaries.

Engagement in life: use of occupation-focused practice for adults in secure hospitals

Genevieve Smyth (College of Occupational Therapists)

Abstract

The principles of Recovery emphasise the need to build a meaningful and satisfying life as defined by the person themselves, being able to take on satisfying social roles and rediscovering a sense of personal identity (Shepherd et al 2008). Meaningful activity and occupation can be vital in this journey and are of particular importance in secure settings.

Despite this, recent Care Quality Commission reports have highlighted the variance of opportunity to engage in meaningful activity for those detained under the Mental Health Act. So two years ago the *College of Occupational Therapists Specialist Section -Mental Health Forensic Forum* decided to highlight the importance of activity by the development of evidence based practice guidelines. Led by Dr Jane Cronin-Davis, this work asked "*What evidence is there to support the use of occupation- focused practice in secure hospitals*?" From an initial search of 4028 articles, 34 were critically appraised and finally used. The Recovery orientated recommendations cover the need for meaningful occupational choice throughout the week, the need to work towards paid employment, the need to provide healthy living programmes including exercise and the importance of liaison with community services to facilitate pro social activity.

The guideline has been accredited by the National Institute of Health and Care Excellence (NICE). In addition to improving the service user experience it is hoped that "*This practice guideline confirms the role of occupational therapy...the emphasis placed on the engagement of service users in occupation centred care that gives meaning and value, hope and aspiration is core to a Recovery based approach*". Ged McCann, Associate Director of Commissioning, Foreword, p*vi*.

COT (2012) *Occupational therapists' use of occupation-focused practice in secure hospitals. Practice guideline.* London, COT. Available at www.cot.org.uk/publications.

Shepherd G, Boardman J, Slade M (2008) *Making Recovery a reality*. London: Sainsbury Centre for Mental Health.

"No force first": how do ward managers review aspiration to zero restraint?

Lisa Gale/Andy Mercer/Phil Morgan/Sue Clarke

Abstract

One of the fundamental challenges for recovery orientated in patient services is how can recovery principles be reconciled with the use of restraint and seclusion.

A number of organisations in the USA have reduced their levels of restraint to zero. In the UK, MIND has launched a campaign to end face-down restraint.

In Dorset HealthCare 'The aspiration towards zero restraint' project was launched. After some initial meetings and despite having high level sign up the project hit significant barriers. In order to understand these barriers more fully and to identify ways around them, two focus groups were established, exploring the views of Ward Managers. This presentation will describe the findings of these focus groups and the next steps in taking the project forward.

Abstracts – Breakout Session 3

Service User Experience

There and back again! How two people implemented and built on acquired skills learnt from 'The Living with Bipolar Disorder Course' to re-engage in life

David O'Loughlin, Kerry Pearce, Andy Potter (Dorset HealthCare University NHS Foundation Trust/Bournemouth University)

Abstract

Two 'Peer Specialists' will present how they put into practice what they learnt from the 'The Living with Bipolar Disorder Course' & how they have subsequently started rebuilding their lives.

The **'Living with Bipolar Disorder Course'** is a 13 week psycho education programme that has been running since 2003. It is open for people who have or think they may have bipolar affective disorder. It helps people acquire a psychosocial understanding of their difficulties; develop skills in active self-management, giving them a sense of control & personal responsibility. "The dog learning to wag the tail, rather than the tail wagging the dog" has been quoted several times in course evaluations.

Although limited, strong evidence has emerged supporting a group intervention approach for bipolar affective disorder {Colom et al (2003, 2005 & 2009), Castle et al (2007 & 2010) & Straughan & Buckenham (2006)}. Russell & Browne (2005) highlight 10 strategies for staying well with bipolar disorder which are incorporated into the Course.

Attending the course can be challenging, both emotionally & intellectually. Students who get the most from the course are able to personalise & integrate these strategies into their life. Two 'Peer Specialists' will demonstrate with personal examples, how they did this & subsequently consolidated what they learnt. They will also reflect on their attitude & approach to living with bipolar.

The presentation will briefly describe the 'Living with Bipolar Disorder Course'. This will be followed by personal reflections of 'Peer Specialists' exploring the path they have taken towards their recovery.

Making sense of the stigma of psychological help-seeking: an interpretative phenomenological analysis

Simon Whalley (Regents University, London)

Abstract

Objectives: This qualitative study aimed to investigate the experience of the stigma surrounding seeking psychological help. Key research questions focused on what it was like for participants to feel stigmatised about being in therapy.

Design: The study was a qualitative design, using an Interpretative Phenomenological Analysis (IPA) method. This method was chosen for its ideographic and double hermeneutic nature, allowing each participant's stories of feeling stigmatised about their therapy to be clearly heard and understood.

Methods: Eight adults with experience of feeling stigmatised about being in therapy participated in semi-structured interviews. Interviews were recorded and transcribed verbatim. The interview data were analysed and sorted into emergent themes, super-ordinate themes and finally master themes.

Results: Analysis yielded four master themes around stigma and help-seeking: the hidden self; critical others; justification of therapy; and strength and weakness. These themes suggested that seeking psychological help for the participants was often challenging and that therapy was seen as a stigma marker reminding others of mental health stereotypes, such as dangerousness, unpredictability, and weakness. Furthermore, the data also suggested that participants often felt a strong need to justify their reasons for seeking therapy to other people.

Conclusions: The findings are important for the field of Counselling Psychology and suggest psychologists may be well placed to help acknowledge and tackle feelings of stigma for the stigmatised client. Furthermore, studies such as this could help promote better awareness of the benefits of attending therapy and help to break down the perceived negative stereotypes that exist for psychological help-seeking.

It's time to talk: three short films about personal recovery from mental health issues

Dr Andy Mercer/James Palfreman-Kay (Bournemouth University),

Abstract

This presentation will feature three short films made by BU in conjunction with Dorset HealthCare University NHS Foundation Trust, Dorset Healthwatch and Dorset Mental Health Forum in support of the Time to Change campaign, challenging mental health stigma and discrimination.

The videos feature people who live, work and study in Dorset sharing their stories of their personal recovery from mental health issues. The presentation will describe the background to the films, discuss issues arising before, during and after the filming, and present the initial findings of a short online survey looking at attitudes to mental health. The survey targeted people who accessed the films via You Tube, and the findings provide some indication of the potential impact of raising public awareness of mental health issues though accessible media.

Focus on Intervention

Comfort Zone: one step beyond – drama-therapy as a drug and alcohol treatment and recovery intervention

Katrina Lahmann, Yasmine Owarish (Dual Diagnosis Network Haringey/Haringey Advisory Group on Alcohol)

Abstract

The foundation of Drama-therapy is person-centred and process-led, making it a viable model for drug and alcohol treatment and recovery intervention. This presentation will offer initial evidence for the effectiveness of a Drama-therapy therapeutic theatre model with a diverse cohort of drug, alcohol and mental health service-users. Through a pan-borough partnership funded by Haringey Drug and Alcohol Action Team (DAAT), a registered Drama-therapist /Dual Diagnosis professional has conducted a three-phase pilot (January 2012-current) with 32 participants. The Drama-therapy sessions are offered on a weekly group basis, focusing on developing self-generated metaphors and narratives, expanding perspective, and working towards group performance within selected recovery-focused events. Sessions are responsive to needs of individuals and the group as a whole with emphasis on building participant's "recovery capital," not only as a group but also as part of the wider treatment community and the local community as a whole. The project has

supported participants to develop life skills such as negotiating change, problem solving and managing process.

In assessing the impact of Drama-therapy in this context, quantitative data will be presented, exploring changes in participants' alcohol and other drug use; offending; employment, training and education; housing status; psychological, physical and overall well-being, collected using Public Health England's Treatment Outcomes Profile (TOPS) tool and a project evaluation questionnaire. Qualitative data will also be presented in the form of case studies and participant feedback.

The benefits and challenges of this model will be outlined with reference to feedback from participants, services, commissioners, and the wider community. In closing the presentation, screening a short group performance will lead into Q&A's with participant and the Drama-therapist lead. This project demonstrated a strong sense of ownership among participants and a continuing peer support network. Trusting the therapeutic process is the key learning to enable stepping beyond the comfort zone.

Evaluation of group-based ACT for family carers of people with Dementia

Dr Sam Dench/Sue Clarke (Dorset HealthCare University NHS Foundation Trust)

Abstract

This present pilot study is testing the effectiveness of a new, four session (10 hour) adapted group-based Acceptance and Commitment Training (ACTr) protocol for family carers of people with dementia. The primary research question is: For family carers of people with dementia, is ACTr an effective intervention in improving quality of life, psychological flexibility and self-compassion and reducing psychological distress. The first of two pilot ACTr courses was completed in 2012 and a second is currently underway.

Results: For carers (N = 7) attending the 2012 ACTr course, the mean satisfaction rating on the Client Satisfaction Questionnaire (CSQ)) was 26.7 (83%). For the group there were significant changes between carers' pre- ACTr and follow-up scores on all but one (the General Health Questionnaire (GHQ)) measure. These changes were consistent with less distress and healthier psychological functioning. Specific changes: Self Compassion Scale (SCS): Significant increase in median total self-compassion score and significantly improved median scores on two subscales (increased self-kindness and a reduction in over-identification). Revised Memory and Behaviour Checklist (RMBC): Significant reduction in mean total score for carers' distress level/reaction in relation to dementia related behaviour and in mean score on one subscale (reduction in distress level/reaction to disruptive behaviour exhibited by the person with dementia). Valued Living Questionnaire (VLQ):

Significant increase in mean total score for living consistently with personally held values. Cognitive Fusion Questionnaire (CFQ): Significant decrease in median total score for cognitive fusion.

Summary: Preliminary results suggest that ACTr shows promise in pro-actively assisting family carers of people with dementia with coping with stress and with promoting their psychological well-being.   This is particularly important given the heightened risk of psychological distress that carers face and the limited published research demonstrating interventions that are effective in psychologically supporting carers of people with dementia.

Understanding Compassionate Care in Mental Health Care Workers

Dr Georgina Taylor, Prof Sue Clarke and Prof Bob Remington (Dorset HealthCare University NHS Foundation Trust)

Abstract

A lack of compassionate responding towards clients with a personality disorder (PD) is particularly evident amongst healthcare professionals (Wright, Haigh & McKeown, 2007). Although this is documented to result in a number of negative implications for the client (e.g., Aviram et al., 2006), little is known about the implications for the professional. As such, this study aimed to model the relationships between healthcare professional's attitudes towards clients with a PD and the outcomes for both clients and staff. A total of 140 frontline staff completed a series of self-report measures to assess attitudes towards clients with a PD, ACT processes (believability of thoughts and psychological flexibility) and client (social distancing and therapeutic relationship) and staff outcomes (psychological distress and burnout). Bootstrapping analysis indicated that psychological flexibility fully mediated the relationship between stigma and burnout and stigma and psychological distress (negative outcomes for staff). Additionally, results indicated that believability of thoughts partially mediated the relationship between stigma and the therapeutic relationship and stigma and social distancing (negative outcomes for clients). As such, the present study provides new insight into staff stigma towards PD clients, suggesting that the stigmatising attitudes of healthcare staff can have negative implications for both the client and the professional. Moreover, the study confirms that both psychological inflexibility and believability are key processes in understanding the workings of the relationship between stigma and negative outcomes. Thus, training aimed at defusion (reducing believability of thoughts) and acceptance (increasing psychological flexibility) may be helpful in promoting therapeutic relationships and increasing staff wellbeing.

Service Delivery & Evaluation

How do we lead a recovery based service? Transformation or incremental steps? A leader's workshop

Inger Kari Nerheim (Stavanger University Hospital, Norway)

Abstract

The recovery based approach has a clear message of citizens' rights, clearer than previous efforts to implement user participation in various forms. In treatment and in care, everywhere where a help-seeker and a help provider meet, the foundation is a level base. The person owns his/her own life. Many services, even the best ones, came to have a practice which inevitably took over individual's lives, their decisions, and their future. When this at best caring, at worst, coercive and scary kind of mental health system is changing, we first see the effect for the patient/citizen. Then we see changes in the carer/professional as well. We often call both effects a transformation. How must our leadership change, to give the recovery approach the best possibilities to develop? How will our leadership have to change, when it is no longer leading a hierarchy, but a true mutuality and citizen based service? When will the first specialist mental health service be led by a director who started out as a Peer Support?

Successfully integrating live synchronous, internet-based text, CBT into Step 3 IAPT services

Sarah Bateup (Psychology Online)

Abstract

Introduction: Research has shown that live text based therapy provided via the internet to be an effective method of delivery (The Lancet 2009). The conclusion of this study was that this method of delivery could broaden access to CBT. PsychologyOnline ran pilots in NHS IAPT services to consider whether online therapy could be integrated into the IAPT environment.

Method: Step 3 IAPT waiting list patients were contacted by phone to offer the choice of online therapy. Those who chose to do this were sent an activation link to register for online therapy and were matched to BABCP accredited CBT therapists, according to times preferred by patients. Therapists met with patients weekly, mirroring the session durations

and therapy length of traditional IAPT step 3 therapies. IAPT Minimum Data Set (MDS) questionnaires were completed online before every session.

Results: Online therapy was successfully integrated into IAPT service including compliance with information and clinical governance.   Supervision guidelines followed those of IAPT. PsychologyOnline supervisors were meta-supervised by service supervisors. Communication between supervisors to ensure consistency was identified as critical. NHS IAPT therapists were trained to provide therapy alongside PsychologyOnline therapists. Information about user requirements was gathered including patients' preferences for weekday evening appointments (6pm-10pm) and the need to develop an online facility for completing MDS questionnaires and reviewing scores. Recovery rates appeared similar to those achieved in standard IAPT delivery

Lancet (2009) Therapist-delivered internet psychotherapy for depression in primary care: a randomised controlled trial, The Lancet; 374: 628-34

The individual recovery outcomes counter (I.ROC): measuring personal recovery outcomes in mental health services

Bridey Monger (Penumbra)

Abstract

Principles of personal recovery; personalisation (enabling people's care and support to be built around their personal needs, choices and aspirations); and outcomes-based approaches, are shaping the direction of service provision in Scotland, but developing tools locally that are effective in measuring results in these areas, remains a key challenge. Mental health charity Penumbra was keen to face this challenge in order to deliver the best possible outcomes for people within an organisational culture of continuous improvement.

The Individual Recovery Outcomes Counter (I.ROC), a 12-item recovery questionnaire, is Penumbra's answer to this challenge. Designed to measure recovery at all levels from the personal to the organisational, I.ROC is the only recovery validated outcomes measure developed in Scotland. I.ROC has been through initial validation testing, and is now being used throughout Penumbra and further afield.

 Here, we describe the organisational and cultural changes Penumbra has made in order to ensure that its strategy, philosophy, values and practice reflect a recovery focus. We will demonstrate how Penumbra has achieved these cultural changes, and describe how I.ROC forms part of Penumbra's HOPE framework and an outcome based approach. We will explore how I.ROC can be used in order to facilitate a personalised, recovery focussed

service and how this tool is beginning to be used in wider services throughout Scotland as a measure of recovery and wellbeing.

We will present the results of the initial validation of I.ROC, and outline preliminary findings from continuing research projects with external organisations across Scotland, demonstrating its validity, reliability and utility within wider settings.

Specialist Settings

A holistic multi-disciplinary group approach to supporting flexible eating in young people with LD

James Cook (Dorset HealthCare University NHS Foundation Trust)

Abstract

Purpose: To explore the use of a programme of work aimed at addressing the causes of disordered feeding patterns in young people who have a learning disability and autistic spectrum disorder, given evidence which shows a high prevalence of these difficulties within this population, while supporting parents to set goals and take ownership on their child's difficulties.

Methods: Initial development involved a literature review and a reflection on current practice, which allowed identification of gaps in provision. A tool was developed to gain information on each participant's eating, as well as the parent's attitude towards food. This was analysed allowing customisation of approach based on the causation of the disordered eating; this drew on existing isolated projects to develop a goal-based approach to eating and drinking which utilises the multi-disciplinary team within both home and educational environments. Parents were engaged at various stages during the project, allowing setting and reviewing of goals. Data from parent's goals and participant's observed & recorded progress was analysed to review the impact of this programme. Final analysis includes a quantitative statistical analysis in addition to conclusions drawn from qualitative data.

Results: Data collected from parents show a positive change in behaviour in 83% of participants, and suggests transferable change from group to home environment. This is reflected in observed changes in behaviour and self-reported changes from young people. There also appears to be a positive relationship between parental participation and the overall progress made by the child.

Conclusion: The data collected suggests that this approach is having a positive impact on eating and drinking for young people with a learning disability in all settings, allowing them to make more flexible food choices.

Developing Dementia services for people with LD

Dr Hannah Kiddle, Paul Crabbe (Dorset HealthCare University NHS Foundation Trust)

Abstract

People with Learning Disabilities, and specifically those with Down syndrome, are at increased risk of developing dementia as compared with the general population. Historically, dementia services for people with Learning Disabilities in Dorset have been provided on an ad hoc basis and varied considerably across geographical areas depending on the skills and interest of specific professionals in the given team. In 2009, the British Psychological Society and Royal College of Psychiatrists published good practice guidelines providing advice for the assessment, diagnosis and treatment of people with Learning Disabilities and dementia. This presentation will discuss an audit of the Service's adherence to good practice guidelines and the steps being taken to improve dementia care in the Learning Disability Service. In order to improve consistency and adherence to good practice, a pathway for the assessment and treatment of dementia for people with Learning Disabilities has been developed. This presentation will discuss the development and implementation of the pathway, difficulties in the assessment of people who have communication, sensory and learning difficulties, institutional and societal barriers to effective diagnosis and treatment, integration into mainstream memory and dementia services and education for staff, carers and families. In mainstream services, people with dementia and their carers can get support from Memory Cafés. Whilst people with Learning Disabilities are not excluded, there are a number of issues that may make accessing this difficult without adaptation such as earlier age of onset, communication difficulties and lower intellectual ability pre-morbidly. No evidence of the effectiveness of Memory Cafés specifically for people with Learning Disabilities exists. A pilot Memory Café will be set up by the Learning Disability Service to establish whether this would be of benefit for people with Learning Disabilities and their carers. Consideration of the use of intensive interaction in this setting will be explored.

Converting a legal tenancy agreement into a format people with LD can understand

Jon Bryant (Jon Bryant Associates)

Abstract

11 people with Learning Disabilities were given the opportunity to work with a creative consultant to translate a 43 page legal tenancy document into a simple understandable format. The 11 participants had a range of learning problems and were living in supportive housing.

The process of translation occurred over a 9 months period and involved frequent meetings with the consultant in which he visited their home. They formed a 'test panel' reviewing video footage and images to see what made them laugh and what encouraged engagement.

A final video-tenancy agreement was creative and again tested through the panel. The most difficult concepts were either "abstract" ones such as "You must not break conditions of building insurance". Being too graphic or literal around "antisocial behaviour and reporting abuse" where it would be very easy to create concerns, insecurity or anxiety. The same applied in outlining the landlord's right to go to court and dispose of a tenant's possessions in recovering costs, a very rare event but part of the agreement. A right way, wrong way approach provided positive examples by comparison, the tone of voice of the audio clearly affected perceptions of the message. Excerpts from the agreement are available for review.

Conclusions: People with LD can have fuller engagement in life if tools and processes are used to facilitate understanding, even if the content is considered complex and technical. Success factors in the process were: giving time to get to know the people, finding out their preferences, allowing them to review and comment on each draft, using creative methods and familiar imagery. This technique and associated outcomes could be utilised in other situations, particularly in translating treatment manuals and materials for use with this client group.

Forensic Settings

Making links: using recovery approaches to re-integrate the community and the secure environment

Kate Law, Amanda Tidman (Farmfield Hospital, Priory Group)

Abstract

Farmfield Hospital has a strong recovery focus and as part of the approach over the last few years has been actively promoting greater links with the community for service users. The talk will discuss a range of recovery activities now embedded at Farmfield and discuss how these approaches are helping service users to build better community links and how this helps in their recovery journeys. A dual approach of community based groups and activities in the hospital and service user involvement in the community has proven very successful in helping community orientation and reintegration. This dual approach has been useful in promoting more positive and successful ways of living in the community to men who may have been in hospital many years.

Various recovery approaches will be discussed, designed to meet various needs. These include two themed months which have become part of the annual hospital programme. Tackling Drugs Month and Recovery Month both aim to promote service users taking more active and independent responsibility for their own lives and recovery. Considerable emphasis has been placed upon employment and educational opportunities with a range of jobs and courses offered for individuals both in the hospital and in the community and support offered by external agencies to gain employment. Focusing on peer support, organisations such as AA and NA now regularly run meetings at Farmfield. In respect of physical health and developing social skills, a team of service users now regularly play in a community based football league.

These activities and events will be discussed, hopefully with service users also presenting (either in person or on video) their personal experiences of using these opportunities.

How a patient and staff band in a high secure hospital illustrated social inclusion and recovery

Ian Merrick, Alex Maguire (London South Bank University)

Abstract

This presentation describes a process that began with a request made by a patient at a high secure hospital to start a band with two members of staff and another patient. This seemingly straightforward idea had ramifications for the staff in terms of managing patient expectations and scarce resources. Nevertheless, it was ultimately justified in terms of the benefits that were brought to this individual. In keeping with the recovery concept, the group was patient-led and used exclusively patient material, although this placed responsibilities on that patient to direct the sessions. This patient was the "band leader" and as such had to negotiate his way through the mine-field of selecting material, rehearsing and then making a recording which was to his (and the band's) liking. We explore the field of collective music-making as a

microcosm of social interaction, where new and often exploratory behaviours can be tried out in a safe and contained setting. The constraints of playing in the foreground, mid-ground and background are looked at, as is the sense of empowerment and ownership engendered by participation in the group. The patient discovered that his musical prowess was more limited than he originally thought, and the impact on his delusional system is considered. We aim to show how an in-depth exploration of both the musical and lyrical content of the patient's own songs can reveal something of the hitherto little-known inner world of the patient, and perhaps shed some light on his barely explicable offence.

Making recovery a reality in secure settings – piloting the 'secure star'

Peter Crascall (Inmind Healthcare)

Abstract

How readily can the principles of recovery in mental health be applied to a detained client group in secure settings? Can the obstacle of The Mental Health Act be overcome in establishing and maintaining helping relationships that promote independence and hope for the future?

This presentation outlines and discusses the experiences of one organisation that has been involved in the development and subsequent piloting of 'The Secure Star' Outcomes Tool. This is the newly developed variant of the widely used 'Recovery Star' that has been specifically tailored to secure settings.

Key aspects will include:

- The developmental process. In particular how the Secure Star deviated from The Recovery Star, with the associated rationale for the changes.

- The task of training staff teams to apply recovery principles within a low secure setting.

- Experiences of the 'roll out' process, including the particular operational issues that were encountered in relation to working with a client group that may be reluctant to engage with support.

- The findings from the pilot study and how these gave rise to further refinements of the tool.

- Next steps in the implementation process.

Abstracts – Breakout Session 4

Service User Experience

Social innovation in mental health care for black, Asian and minority ethnic communities

Naomi Mwasambili (Community Therapies and Training Service)

Abstract

The prevalence of mental health problems within Black, Asian and Minority Ethnic (BAME) communities has been widely documented. Limited access to culturally appropriate services and information at an early stage has been cited as a common experience of service users and communities who have experiences of the mental health system and services. This presentation will look at how Social Enterprises can develop creative ways to improve mental wellbeing using social innovation and aid recovery. We will discuss how stigma and shame can be addressed working collaboratively with communities and specifically within BAME communities. We will explore the power dynamics within the community and the statutory services and how this serves to continue the cycle of stigma. We will look at practical application of the community development model; how this can be embedded within mental health services, private sector providers and voluntary sector organisations; its role to enhance mental health promotion and how it can be used to challenge the established roles and views of both professional groups and community members. We will discuss case examples of projects we have and are working on that are addressing mental health inequalities in relation to race, culture, disability, religion and spirituality, sexual identity, gender and age. This presentation will be interactive and participants will be invited to share experiences as well as providing feedback on creative ways of working.

The right to be heard: review of the quality of mental health advocacy in England

Karen Newbigging and June Sadd (University of Central Lancashire)

Abstract

Introduction: Independent advocacy has the potential to enhance personal agency and recovery. Independent Mental Health Advocates (IMHAs) are a specialist type of mental health advocate, granted specific roles and responsibilities under the Mental Health Act, 2007 to safeguard the rights of people detained under the legislation. In 2010, the

Department of Health commissioned research into the quality and implementation of IMHA services.

Study aim: To review the extent to which these services were providing accessible, effective, and appropriate support to qualifying patients, and to understand the factors that influence this.

Methods: A multi-method study involving:

- Eleven focus groups with IMHA users, IMHA services, mental health professionals and commissioners

- Shadow visits to IMHA services

- Eight case studies of the access, uptake and experience of IMHA services.

Results: Access and uptake of IMHA services varied considerably and is problematic for marginalised groups. The quality and effectiveness of IMHA was, to a large extent, linked to the extent to which mental health services staff appreciated and understood advocacy. Once service users access the service it is highly valued but its impact is limited by IMHA capacity and the organisational culture of mental health services.

Conclusions: The IMHA role was highly valued by service users, although its full potential had not been realised. Mental health services need to develop a more positive predisposition towards advocacy, distinguishing between independent advocacy and 'best interests' work. The emancipatory and transformative potential of advocacy depends upon the willingness of mental health services relating constructively to the challenges posed.

References: Newbigging, K., Ridley, J., McKeown, M., et al. (2012) *The Right to Be Heard. Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England.* Preston: Uclan

Focus on Intervention

Working together group - the evidence behind the practice

Jennifer Stickney (Dorset HealthCare University NHS Foundation Trust)

Abstract

The high rate of recidivism for forensic patients post discharge suggests some specific support and reflection might be helpful. To test this, a pilot study was set up. The Working Together Group was formed with the objective of supporting specific patients, known to

Dorset Forensic Team, to understand how to transfer skills learnt in secure settings to community living.

The composition of the group was 7 adult males known to Dorset Forensic Team with a primary diagnosis of mental disorder, close to discharge or struggling with community living. All group members were risk assessed prior to the group starting, to ensure their and others safety was maintained.

The group was held in a community setting for 2 hours weekly for 8-week duration, facilitated by 2 occupational therapists and a support worker. Prior to the group starting each group member was interviewed and an Inclusion Web (NDSI 2011) completed. At the end of the 8 weeks The Inclusion Web was repeated, to assess whether the group promotes skills for social inclusion and group members completed a self-questionnaire.

The findings demonstrated that patients a) were more positive about their community, b) increased their access or wish to access community facilities and c) felt more skilled in applying specific community living skills. Clinician perspective recorded that patients' level of engagement in the pre and post discharge process had increased, during the group and afterwards, compared to how they presented prior to the group starting. With these encouraging results, a larger study is planned.

The 'Tree of Life' recovery group in a CMHT in City and Hackney

Corrine Maskell, Perpetua Robert (East London NHS Foundation Trust)

Abstract

This presentation will describe our experience of developing and implementing a 14-session Recovery Group based on the 'Tree of Life' Narrative Therapy approach in a Community mental health team (CMHT) setting. The 'Tree of Life' is a collective narrative therapy approach developed in Africa by Ncazelo Ncube and David Denborough (Ncube, 2006). It uses the metaphors of a tree and a forest to help participants' identity their individual and collective strengths and resources before addressing the 'storms of life'. It was developed originally with children and young people but has now been adapted and widely used with adults. We feel that this approach fits closely with the principles of a Recovery approach in mental health. We will describe how we developed what was originally a one-day workshop into a 14-session group programme which has now become established in our CMHT and has been positively evaluated by participants. The approach has been successful at engaging service users from Black and minority ethnic (BME) communities, who are often under-represented in talking therapy services.

Service Delivery & Evaluation

What was the experience of students and trainers in recovery education centre pilot term?

Phil Morgan (Dorset HealthCare University NHS Foundation Trust)

Abstract

Recovery Courses and Education Centres are being developed across the UK. Dorset was one of the first pioneers in developing one. Central in the way of working is partnership between professionals and experts by experience. Another key feature is that everyone is treated as a student, whether they are a service user, staff or a carer. In order to understand the impact of the pilot term of the REC, qualitative interviews were undertaken with students, NHS trainers and peer trainers. These findings will be presented alongside the first hand experiences of NHS and peer trainers.

Partnership working as a way of creating an environment which supports people to re-engage in life

Sarah Wood (Fromeside, Avon and Wiltshire Partnership Mental Health NHS Trust)

Abstract

Engagement in life is very pertinent to the client group we work with. The circumstances and reasons for being in a secure hospital mean that finding ways to re-engage in life, often in a way that is different from their past is a central part of their mental health and offending recovery.

Secure services are vulnerable to removing people's agency and this can have a significant impact on people's perception that they can re-engage with life. This presentation will look at partnership working as a specific strand of our goal of creating an environment and setting that promotes peoples' individual recovery and encourages a sense of agency and control. We would like to present three domains where we have been developing partnership working.

Training: Service users co-facilitate our induction session on recovery for new staff.

Service users co-facilitate workshops in our service recovery development days.

Organisational service users are members of the Recovery Steering Group. This group meets to plan and enact our vision for the service to ensure that we are creating an environment that supports recovery.

Service users review our policies and procedures so that they are accessible to service users in order that service users can be clear and informed about the policies that often influence their lives on the wards.

Sharing expertise and experience: through Newsletters, Peer links and Mentoring we hope to provide forums where service users can share their experience and knowledge to help and inspire others. We will reflect on the benefits and challenges of partnership working and our hopes for the future.

Specialist Settings

You're in the number one recovery-focused approach using a psycho-social bio approach with young people experiencing psychosis

Dr Kate Chapman (Avon and Wiltshire Partnership Mental Health NHS Trust)

Abstract

Early intervention teams have been set up across the country to offer evidence based interventions to young people presenting for the first time to services. South Gloucestershire's Early Intervention in Psychosis team offers a three year service for young people experiencing their first episode of psychosis, and in order to be eligible for the service the presenting problems need to come under the umbrella of 'psychosis'. Once accepted onto the team's caseload, 'You're in', we develop a Psycho-Social-Bio formulation that we propose is a useful way of summarising 'our best understanding of what's been happening for you'.

This is based on the following rationale;

1. Labelling someone's presenting problems as 'psychotic' tells us very little about the experiences, or the person.

2. Not everyone experiences psychosis - so why this person, why now, and why in this way?

3. Psychosis can be seen as an understandable psychological reaction to things that have happened to a person.

We advocate a standardised approach that begins with giving out a leaflet based upon a Psycho-Social-Bio understanding of psychosis and offering this as a 'Theory B' that might also explain what is happening. We then obtain as much information as possible about a person's life (often using a timeline) and draw on psycho-education about the life experiences that have been linked with 'psychosis' (using a continuum approach), bringing this together onto a generic formulation diagram.

The benefits of using this approach are that it ensures that young people coming to the service are given a very clear and consistent message that their experiences are understandable reactions to life events rather than symptoms, and provides a well-developed formulation that guides choice of intervention within a collaborative, recovery focused approach.

Notes Pages:

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Evaluation Form

Recovery Focused Conference – 6th September 2013

We would love to receive any feedback that you would like to share with us. Your ideas will help us make our future events even better.

Name: (optional)……………………………...

Please rate the event using the following scale

1=very poor, 2=poor, 3=good, 4=very good, 5=excellent	1	2	3	4	5
Information prior to the event					
Overall impressions of the event					
Content relevant to professional requirements					
Venue and facilities					
Catering					
Organisation of the day					

Any further comments
Presenters and delivery of the sessions including keynotes
Expectations prior to the event and if these were met

Please turn over…..

Changes and improvements to future events

Further comments

Thank you for taking the time to complete this evaluation.

At the end of the event, please hand in this form or return to Jo Downey, Bournemouth University, School of Health & Social Care, Royal London House, 7th floor, Christchurch Road, Bournemouth, Dorset BH1 3LT.

Please collect your CPD Certificate on your way out.

We will re-cycle your badge if you leave it on your way out.