Clinical Psychology Forum

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The notion of recovery in mental health has become ubiquitous following its inclusion in a range of government policy initiatives in the early 2000s, leading to the development of innovative approaches like the employment of peer support workers and moves to draw more on educational rather than medical discourses, as seen in the development of recovery colleges. However, the notion of recovery has also been critiqued by many in the psychiatric survivor movement as well as critical researchers and clinicians (Dillon, 2011; Harper & Speed, 2012; Pilgrim & McCranie, 2013; Rose, 2014). Has the recovery movement led to fundamental change in mental health? Or has it been a case of ‘old wine in new bottles’ where services do pretty much what they did before but with different terminology? The articles in this special issue provide a range of perspectives. Some authors adopt recovery wholeheartedly and present examples of innovative work or evaluations of projects. Other contributors adopt a more critical perspective – seeing some value in it but warning of its limitations and suggesting alternative ways forward.

In this foreword we thought we would discuss three challenges facing the notion of recovery, drawing on some of our own work examining the implicit assumptions of recovery discourse (Harper & Speed, 2012).

The first challenge is the way in which recovery discourse can individualise social problems. One of the strengths of recovery models has been the emphasis put on the notion that recovery is an individual journey – different for everyone. There is an apparent attempt to escape normative notions (e.g. that recovery is synonymous with symptom reduction), but this may not follow through in everyday practice where outcomes often emphasise symptom reduction and services are still focused on medication. A recent survey reported that 84 per cent of service users had received medication in the previous year (of which, 87 per cent had been prescribed it for over a year), whilst only 47 per cent had, in addition, received other kinds of intervention (Care Quality Commission, 2014). Concentrating on individuals can inadvertently lead us to neglect the causal role of social inequality in emotional distress. When faced with a lack of opportunity in terms of employment, or poverty, or an inability to access adequate support because of changes to the welfare system, identifying the individual as the sole arbiter of their fate can be hugely disempowering. Moreover, there is also an implicit message that the individual is somehow responsible both for their fate (because, say, of their ‘vulnerability’ – Boyle, 2003) and for their future progress. This ‘responsibilisation’ is fundamental to the neoliberal ideology that has underpinned governmental policies since the 1980s.

The second challenge is that much recovery discourse de-politicises individual experience. The acknowledgement of personal experience is key to the popularity of recovery amongst many service users, as can be seen from a number of articles in this special issue. However, the danger is that experience is only understood in an individual context and in dyadic conversations between service users and professionals rather than at a social level. We could learn a lot from the feminist motto that ‘the personal is political’ (Hanisch, 1970). Many of the causes of distress lie in social inequality and many of the actions needed to address inequality need to be taken collectively with others. Unfortunately, in mental health the personal is often just seen as the personal. Individual experience is not made sense of in a political context and there is little opportunity for consciousness-raising in groups and indeed action for social change (although see Dillon,
2011, for a notable exception). For example, many service users have never heard of the survivor movement. What chance is there of recovery if the underlying material conditions of inequality, stigma and discrimination go unaddressed and service users lack opportunities to engage in processes of social change?

The third challenge is that, by focusing on current strengths and future goals, recovery implicitly draws on notions of weakness and deficit. The narrative therapist Michael White (2004) has observed that ‘people would not understand their difficulties in life as expressions of weaknesses and deficits if there were no strengths and resources’ (p.136). Whilst strength and future-focused talk superficially avoid this, they are implicitly invoked in language – for example, we can’t understand health without reference to notions of illness. How else might we talk? White suggests focusing on intentional narratives, those featuring values, beliefs, hopes, dreams, visions and commitments to ways of living. Boyle (2003) suggests we need to address the social causes of distress rather than purported vulnerabilities in individuals. In this special issue, Rachel Perkins argues for a move towards a rights-based social model rather than a health-focused model. Peter Beresford, for his part, suggests that the vibrancy of ‘mad studies’ provides another hopeful way forward. Whether we choose to work with existing structures, or criticise them for not going far enough in addressing the attendant inequalities identified here, there can be no doubt that recovery is a political act. The issue for survivors, service users, practitioners and researchers is whether we decide to embrace the political or ignore it.

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I BECAME interested in student mental health as an undergraduate and while volunteering for Student Minds. Student Minds is the UK’s student mental health charity, with a national network of student-led peer support groups and campaign groups. Through my work I became aware of the unique struggles students with mental health difficulties face, including the challenges of accessing appropriate support.

University is often regarded as a positive transition; however, 10 per cent of university students drop out (Paton, 2013). Research indicates that 30 per cent of university students demonstrate clinical levels of distress (Kerr, 2013) and that mental health difficulties are widespread among undergraduates (Kerr, 2013). Considering that almost half of young people in the UK enter higher education (Adams, 2013), this is a large proportion of our population facing these struggles. Holding this in mind we must take the needs of this population seriously.

As a charity we were all too aware of the challenges students face regarding their mental health difficulties and receiving the support they need. Due to the transient lifestyle of students it can be difficult to receive consistent support. Unfortunately, the NHS is not set up to cater for this population, despite 1.3 million students living between home and university (Leach & Hall, 2011).

In addition to being associated with increased risk of mental health problems (Bewick et al., 2010), the transition to university coincides with the onset of over half of all mental health conditions (Kessler et al., 2007). Included in this are eating disorders, which develop in adolescence and early adulthood (Lucas et al., 1999). Eating disorders are a group of disorders which are all characterised by abnormal eating habits (Horgan & Sweeney, 2008).

Eating disorders require support, both at home and university, for both physical and mental health treatment. Eating disorders therefore provide a good example of where integrated support is needed. To investigate the difficulties faced by university students with mental health conditions I co-wrote a report with Nicola Byrom focused on students with eating disorders.

Through our report we heard about the challenges students face when trying to access support from home GPs whilst registered as a permanent resident at university. We were given examples of where GPs had refused to conduct blood tests on temporary residents despite it being part of their care plan. Students also reported waits of over six months to get assessments at specialist services. In some situations these appointments were offered whilst the student was back home or in the middle of exams meaning they could not attend. As a result the student was put to the bottom of the waiting list.

In addition to student voices we heard from healthcare professionals who detailed the various challenges of finding out how to
refer and who to refer to, and trying to communicate between teams that could be at the other end of the country.

In response to these concerns we made a number of recommendations. These include raising awareness of Who Pays? guidance to inform healthcare professionals that people are entitled to the same care whether they are a temporary or a permanent resident. In outpatient care it is the clinical commissioning group (CCG) who provide the services that pays, regardless of the type of GP registration they have.

We recommend methods to improve communication between healthcare professionals to enable support to be put in place before students arrive at university and in both locations. These include the use of secure e-mails or encrypted memory sticks and copying students, and where appropriate family members, into all correspondence so they can present it at appointments with other healthcare professionals.

We also strongly encourage the use of new technologies to improve the flexible and consistent support that can be offered. These include apps which provide 24/7 support to students, and also include a platform where the student and healthcare professional can book and have online consultations.

Following our report and petition, calling for the Department of Health to provide better support for university students with mental health difficulties, we met with Norman Lamb (Minister of State for Care and Support). This has resulted in conversations with the Department of Health and NHS England, influencing strategies for young people. There is work to produce guidance for CCGs to enable them to better support university students with mental health conditions.

We hope to continue this work to influence policy, whilst collaborating with the Department of Health, NHS England, universities, healthcare professionals, CCG’s and, most importantly, students and carers.

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MY INTEREST in global psychosocial and public mental health grew after working for The Banyan, a grassroots mental health non-governmental organisation (NGO) in south India. It began with two local social work students horrified by the abusive state treatment of women suffering from mental illness and homelessness (e.g. Human Rights Watch, 2014) and developed over 20 years to provide specialised services including medication, psychological therapy and vocational training. The appalling experiences of these beneficiaries led to my desire to complete an MSc in International Development. Mental health in this global context has been referred to as ‘the Cinderella of public health care’ (Desjarlais et al., 1996, p.36). My dissertation, completed in Sierra Leone, highlighted this neglect. Sierra Leoneans had experienced the extremes of armed conflict and poverty leading to exorbitantly high levels of traumatic stress (De Jong et al., 2000), compounded by under-resourced institution-based psychiatric services and ad hoc NGO interventions based on limited and insecure funding. This devastating lack of services influenced my desire to train clinically to learn about models of intervention in settings of political instability, armed conflict or chronic poverty.

This ambition led me to the Doctorate in Clinical Psychology at Queen’s University Belfast where I completed placements in adult, child and adolescent mental health, learning disability and two specialist placements, one of which was in a psychological therapy service for psychosis. These experiences taught me that the ongoing influence of Northern Ireland’s 30 year civil conflict, known as ‘The Troubles’, posed a clear challenge to mental health services in responding to psychological trauma that was present, not past. Many models of psychological trauma (e.g. Ehlers & Clarke, 2000) assume a traumatic event is in the past and that the perception of current threat is not a reflection of current reality. However, many people accessing services had ongoing experiences of sectarian threat or violence, and many symptoms of traumatic stress such as hypervigilance were often adaptive, albeit distressing. As a therapist trying to relieve this distress, feelings of helplessness and ineptitude were often triggered.

With this feeling of helplessness I embarked on my second specialist placement, in the psychosocial department of the Palestine Red Crescent Society in the occupied Palestinian territories. The entire population were affected by the ongoing armed conflict, compounded by checkpoints, military presence and walled captivity (Giacaman et al., 2011). In this different culture and in an unstable environment, my usual reliance on individual trauma-focused cogni-
tive behavioural therapy was clearly incongruous with the setting. Even culturally and contextually adapted interventions such as narrative exposure therapy (Robjani & Fazel, 2010) still tended to lack large-scale public health approaches, missing the importance of normalising emotional and behavioural reactions to war, promoting psychological protective factors and preventing mental illness at a population level. The reality is that millions of children face day-to-day exposure to violence and insecurity (Unicef, 2006). My placement opened up doors to see different ways of working in an attempt to address this reality. The department drew on the Inter-Agency Standing Committee model (IASC, 2007), using wide-scale interventions such as community mobilisation and psychological first aid (see Bosqui, 2014). This reached thousands more children and families than a specialised trauma service. Using this model relieved some of my helplessness but also helped me to tolerate and contain the feeling, knowing it was also a normal reaction to an uncontrollable and unfair therapeutic context.

The IASC model has huge relevance for many different populations, including those within the UK, but its development and implementation suffers from a lack of quality research (De Jong et al., 2014). Now back in Northern Ireland, I have been inspired by the hard work of practitioners across the globe, from India to Palestine, and hope to use this inspiration to help improve public mental health here. I currently work at the Centre for Public Health on a migrant mental health research project and I support refugee services as part of the Psychosocial Team in the British Red Cross. My experiences before and throughout training have helped inform this work, to understand the larger context surrounding individuals and their well-being, and to drive to help and address issues despite how helpless they may make me feel. There is not just a place for clinical psychology in global public psychosocial and mental health, but there is a responsibility to act; to research, evaluate and improve interventions, and to inform policy and procedures in order to reduce the tragic consequences of inadequate care.

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Challenges for the recovery movement in the US: Will its light reach the darkest corners?

Jessica Arenella

The ‘RECOVERY’ movement and model, as applied to mental health is a welcome advance, particularly after ‘Decade of the Brain’ (1990–1999) and the ‘Decade of Behavior’ (2000–2009). Having started my study of psychology in the US in the early 1990s, I felt for many years at odds with the mainstream focus on broken brains and symptomatic relief, with relatively little attention to the humanity of the client and the importance of personal relationships as healing. Indeed, working as a psychotherapist with people diagnosed with schizophrenia and other types of psychosis can be a bit lonely, as your peers tend to perceive you either as a crackpot or a martyr! Since the rise of the recovery movement, however, I have had more students, families and colleagues express interest in my work with clients previously considered unreachable and best managed by medication and counsellors that check up on compliance with medication. It has been encouraging to witness the rise of services such as peer-run crisis centres, peer-run ‘warm-lines’, yoga classes and hearing voices groups in the US.

Simultaneously, though, there has been a massive epidemic of criminalisation of psychiatric patients, either through incarceration in jails and prisons, or through forced outpatient treatment and restriction of rights. This has contributed to some skepticism on my part about the adoption of the recovery movement and if we really know what we are getting into. How can we explain that a nation whose largest mental health institutions are jails and prisons is currently using the language of recovery and that state institutions are hiring increased numbers of peer counsellors? Will the recovery movement reach the majority or will it merely lull us into thinking that mental health treatment is progressing?

Just because the recovery model has good ideas, don’t think that its being adopted for good reasons

Here in the US, several states have sued pharmaceutical companies for illegally promoting off-label use of antipsychotic medications, especially for children. The states have sued because they were paying for these expensive medications and they were misled. Were they suing because they were concerned about the welfare of these children? Were they outraged that they were pathologising millions of poor and traumatised children in the foster care system? I do not know for sure, but I am doubtful. I suspect that they wanted money back to fill their giant deficits, at worst, or at best to fund treatment as usual.

I fear that the embrace of the recovery model may be driven by economic concerns, as there is a popular misconception that doctors are driving up the cost of healthcare with nefarious billing practices and unnecessary care. While there are certainly instances of this, reimbursement for mental health care has been steadily declining over the past decade. There is a trend toward hiring technicians and less educated professionals and paraprofessionals, which lowers the rate of compensation even further.

…the embrace of the recovery model may be driven by economic concerns…
There are fewer and fewer employment opportunities for psychologists as the hospitals remunerate highest psychiatrists who can prescribe. In hospitals, social workers are generally hijacked from their original role as advocates for the poor, abused and neglected, and instead are used as tour guides of the byzantine world of social service and entitlement services (ie. ensuring that paperwork for health insurance is updated, rent is paid and appointments are kept). The role of psychologists, professionals who study thoughts, emotions and behaviors, has been marginalised. The legacy of humanistic and existential psychologies, obvious allies to the recovery paradigm, has not encouraged a resurgence for the role of psychologists to practice such therapies.

Despite the decline in the popularity of psychoanalysis, I still find a great deal of worth in the observations of a few analysts than I find most anywhere else. British psychoanalyst, D.W. Winnicott – a product of lay analysis and not inclined to promote professional elitism – nonetheless offered one of the most trenchant justifications for professional psychotherapy. In 1971, Winnicott was asked by a group of priests how to differentiate between a person whom they might help and a person who requires psychiatric treatment. Winnicott explained that, ‘If a person comes and talks to you and, listening to him, you feel he is boring you, then he is sick, and needs psychiatric treatment. But if he sustains your interest, no matter how grave his distress or conflict, then you can help him alright.’ This is when the role of a professional psychotherapist may be helpful. If a person, ostensibly suffering terribly, is provoking boredom, it is likely that there is a powerful force at work that is threatening to both the client and the therapist. While one need not label the person ‘sick’, I do believe that it is tempting to give in and act out on feelings of boredom, hostility or even excessively positive feelings toward clients unless there is sufficient education and training regarding self-reflection and analysis of one’s own thoughts, feelings and reactions to the client. Clients who receive psychiatric services have often worn out their welcome with family, friends, partners and clergy. The recovery model will need to identify how it will address such clients.

Recovery suggests that you had it covered in the first place

Another challenge to ‘recovery’ seems pedantic at first glance: How does someone recover something that they never had? The mental health symptoms are often just the tip of the iceberg in terms of life difficulties. There is ample research implicating physical and sexual violence, neglect, poverty, homelessness, unemployment, inadequate education, racism, homophobia and other forms of discrimination in mental distress. Is the recovery movement prepared to address systemic disadvantages and the legacy of disenfranchisement that many users of mental health services are burdened with? While the current mental health system has insufficiently engaged with such issues, it is not clear that the recovery paradigm will be able to sufficiently address these issues either.

Those who have been barraged by a slew of disadvantaged socio-economic and traumatising forces, often end up chronically institutionalised with a hodgepodge of difficulties interpersonally and fairly destructive ways of managing and expressing their feelings (aggression, violence, pervasive mistrust, re-enacting trauma) that often alienate potential carers. Additionally, these clients have often been prescribed psychoactive medication from childhood and adolescence. These medications may not only mask the need to develop mature emotional and behavioral management strategies, but actually hamper the brain’s capacity for regulation. The literature regarding withdrawal of selective serotonin reuptake inhibitors (SSRIs), serotonin–norepinephrine reuptake inhibitors (SNRIs) and antipsychotics resulting in rapid-onset return of symptoms or even new symptoms is thought to be triggered by the brain’s adaptive response to the flooding or starvation of neurochemicals at receptor sites. These are men and women who may have no recollection of a period of health and have not been able to establish themselves outside of institutions (group homes, halfway houses, jails, hospitals). While I believe that recovery is possible for all, there are significant challenges to recovering when a person never had the bases covered in the first place.
These are the musings of a clinical psychologist, and while I have had my own ‘lived experience’ with depression and anxiety, I primarily identify as a mental health professional. I was encouraged to seek out the perspective of others who identified as ‘in recovery’. I sought the opinion of Rodney Waldron, currently employed at Manhattan Psychiatric Center (a state run long term in-patient treatment facility) as a peer specialist who works daily with many of the folks whom I’ve identified as presenting challenges to the recovery paradigm. I had met Rodney more than a year before, as a co-facilitator of one of the first in-patient voice hearing groups in a New York hospital. After giving him a copy of what I had written, I asked for his response and his own critical observations of the recovery movement in mental health.

First off, Mr Waldron introduced an important caveat to my well-intentioned proclamation that, ‘recovery is possible for all’. He explained that: ‘Recovery is not for those identified as needing it. It is only for those who want it.’ Since ‘recovery’ is not a treatment that can be assigned to a client, it requires a genuine desire and dedication on the part of the individual. This leaves a sizable swath of people with mental health difficulties out of the recovery movement, at least for the time being. The recovery paradigm, like traditional approaches, provides no magic bullet to reach some of the most persistently troubled people – although those in recovery may provide role models and encouragement to those outside of recovery.

Mr Waldron also pointed out that recovery involves a community or an extended family. He suggested that some of the folks who might have the most difficulty participating in the recovery paradigm would be those whose own families were unsupportive and toxic enough to have seriously impaired the individual’s interpersonal skills. Perhaps these are the troubled people that Dr Winnicott thought would need professional help? Mr Waldron had a similar idea. He explained that professional therapists should have a role in offering remedial help in learning to interact effectively within a group or community setting, and that intensive individual psychotherapy should be offered to more in-patients. If some of these deeper issues are worked through with a therapist, the client may become more interested in – and better able to participate in – recovery.

Lastly, Mr Waldron expressed concern about how non-profit organisations and mental health agencies will value and compensate peer providers. He pointed out that a peer counsellor who gets hired for his or her lived experience with mental health issues may not earn enough to make a decent living or be eligible for employee-sponsored healthcare. Additional compensation may not be available despite positive job performance and work experience. Instead, he astutely points out that as the recovery movement is brought into the mainstream system, it is subject to the same educational and class distinctions as the current system. Promotions are offered to those who have secondary and post-secondary university degrees and who are agile with the latest computer skills. Mr Waldron rued that some very talented and inspirational people who interact well with their peers are not hired or promoted because the value of the lived experience and interpersonal skills are devalued in the recovery movement as it becomes co-opted by the mental health system. This tends to result in the same race and class distinctions that exist between patients and professionals getting replicated in the recovery movement, such that the voices of the poor, uneducated and disadvantaged continue to be marginalised.

Mr Waldron and I hope that this critique will be received in the manner in which it is offered, as a respectful and concerned critique that may serve to strengthen the recovery movement.

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Co-production in relation to the constructs of mentalisation and recovery in personality disorder and mental health settings

Rosie Beck, Colin Mattinson & Mark Sampson

This article offers reflective accounts of experiences of co-produced training from perspectives of an ‘expert by experience’ and an ‘expert by occupation’, and suggests processes underpinning co-production-in-action can lead to a wiser, more compassionate organisation and may foster recovery.

Co-production in relation to the constructs of mentalisation and recovery in personality disorder and mental health settings

Co-production has been defined as ‘a relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities’ (Slay & Stephens, 2013). Taking this model into the sphere of mental health services and training, consumers take an active and equal role alongside professionals in both their design and delivery. This requires professionals to act as ‘catalysts and facilitators’ for change (Slay & Stephens, 2013) rather than sole providers and experts. The roles and responsibilities between those who are ‘experts by experience’ (EBEs) and ‘experts by occupation’ (EBOs) will differ, but should be regarded as equal in value. Genuine equality in the partnership between consumers and professionals requires the existing distinction between them to be blurred through altering organisational structures (Needham & Carr, 2009; Slay & Stephens, 2013).

Why co-production in mental health settings may facilitate recovery for people with personality disorder

The principles of co-production appear to represent and encourage healthy attachment relationships and help both parties understand each other’s actions more compassionately. People who are described as having a personality disorder are likely to have experienced early challenges in relationships where certain needs were unmet. We propose that there is something about the co-production relationship which provides a different experience. Recognising users as assets with individual strengths at their disposal that may be utilised in contribution to service design and delivery minimises the danger of regarding users as ‘passive recipients’ with deficiencies or drains on the system (Slay & Stephens, 2013). Instead, co-production requires the recognition of EBEs and EBOs as equal partners, where both parties are acknowledged as valuable resources needed to make change happen. It is this reciprocity which is central to co-production and its potential for effecting change (Cahn, 2004). Professionals move from a role of ‘service provider’ to one of ‘facilitator’. This may more naturally encourage positive attachments through altering the existing structures which may (unintentionally) allow unhelpful dynamics to be played out; for example, invalidating, punitive, coercive or overprotective ‘parents’ doing to or doing for. Having this positive relational experience between the consumer and provider may help the practitioners and the organisation to be less likely to cause iatrogenic harm and better at seeing the other perspective.

Nurturing ‘assets’ may lead to a range of recovery-related outcomes for the individual, such as increased agency and autonomy, a greater internal locus of control, sense of competence, optimism and increased employabil-
ity. However, the relationships in which self-determination is encouraged and achievement recognised will be pivotal. As well as purpose and self-esteem, the processes and outcomes of co-production, both interpersonally and at the environmental level, may build affiliation, acceptance, belonging and safeness.

Research into the common factors of psychotherapies suggests that therapeutic relationships, empathy, warmth, alliance and problem-solving are chiefly implicated in change (Lambert & Barley, 2001; Paris, 2010; Wampold, 2001). Although co-production is not psychotherapy, or a replacement for it, it may provide these interpersonal components for building reparative relationships. Mental disorder may lead to, be driven by, and be maintained by isolation. Cahn (2008) emphasises the importance of mutuality and trust in co-production. Providing a trusting relationship may be the foundation on which self-determination and self-esteem can flourish. Traditional service models in the current economic climate place pressure on providers to deliver care under increasingly restricted resources. A focus on targets rather than therapeutic relationships may lead to the re-enactment of problematic attachment procedures, such as absence, neglect, invalidation or inconsistency of care. Furthermore, burned out, compassion-drained staff may find it harder to attune to the attachment needs of the service user.

One way in which co-production may facilitate recovery for people with personality disorder is that it may enhance mentalisation. ‘Mentalisation’ is a term used to describe the process of attending to state of minds in self and other (Allen & Fonagy, 2006). It is theoretically-inclusive of the concepts of empathy and theory of mind; both are required for mentalisation (Bateman & Fonagy, 2006). Early attachment challenges may lead to difficulties in mentalising (Allen & Fonagy, 2006). Social isolation and alienation can maintain or exacerbate difficulties with mentalisation. Entering into a reciprocal relationship where consumers’ voices are valued and heard by professionals creates a conduit for sharing perspectives, improving understanding and empathy for each other and finding common ground. Working together may facilitate better understandings of the positions and motivations of the other group as a natural outcome of entering into dialogue with one another in solving common problems and making shared decisions. This situation is less likely to occur in less transformational forms of user involvement. The constraints of service provision, understood by professionals but never communicated to consumers, can be more openly explained; users’ responses and ideas for development can be more readily taken on board.

Co-production may offer a forum for improving mentalisation and building positive, reparative attachments. These may be important processes to consider – in addition to hope, optimism, self-esteem and so on – when modelling the complex construct of ‘recovery’. The rest of the paper will discuss experiences of co-production. We draw on the experience of the Personality Disorder Hub Service in 5 Boroughs Partnership Mental Health Foundation Trust (5BP) and the Recovery Academy in Greater Manchester West NHS Mental Health Foundation Trust.

An expert by occupation perspective: Mark Sampson, 5BP – The Personality Disorder Hub Service

Five years ago a Personality Disorder Hub service was commissioned to support 5BP with the aim of helping the Trust become more effective at working with people who would meet the clinical diagnosis of a personality disorder. Initial scoping highlighted a relational breakdown and the development of a poor relationship between providers of mental health services and consumers of services for people with a personality disorder. This was not really surprising as these difficulties are typical in UK mental health services with respect to care and treatment for people with a personality disorder (James & Cowman, 2007).

In order to address these problems it was felt a ‘relational’ solution was required as any successful outcome in improved care for people with a personality disorder in our Trust could only be achieved through person-centred relationships on the frontline (Needham & Carr, 2009). Co-production seemed an obvi-
ous solution as the relationship is central to working together. Consequently, it became the core of our operational model for our Personality Disorder Hub training team.

Obviously, we in 5BP were not the first to do this. Having a strong service user voice and involvement has been central to the National Personality Disorder Development Programme. The Institute of the Mental Health’s Knowledge and Understanding Framework (KUF) – particularly the awareness training package of the KUF – is an inspirational model for co-production. Throughout the model, providers and consumers have worked in partnership to co-develop and co-deliver this personality disorder awareness training.

This training programme was the perfect catalyst for co-production. Eight staff (EBOs) and eight service users (EBEs) were trained together to become trained trainers in the KUF (this enables local trainers to deliver training locally). The process of EBEs and EBOs being trained together prior to the setting up of the service seemed a fundamental component to the service’s success. From the very beginning, equality was established with service users and staff coming in together at the beginning. For further information on how we developed and delivered KUF and co-production in our organisation (see Davies et al., 2014 and Lamph et al., 2014).

Five years on, what have I learned about what working in partnership with people living with a personality disorder has in a co-productive way? From a pragmatic aspect it has been an extremely productive way of working, we have:
- trained over 500 staff;
- developed training packages (one-day bespoke training, carer training, training for CAMHS, police training);
- developed user-led training videos;
- been centrally involved in developing a co-produced eLearning training programme for personality disorder;
- developed new services (e.g. a carer training peer support worker);
- actively engaged service-users in governance and strategy development; and
- moved away from tokenistic involvement to true collaboration.

An additional benefit is how co-production can help enhance professionals’ compassion and awareness and understanding of people living with the diagnosis of personality disorder. It is a unique learning experience that goes beyond what can be delivered in a traditional training course or clinical work. Working together co-producing really provides invaluable insight into people whom you are trying to help. Learning not only about the service user but also about yourself and how you come across to others has been invaluable to me, our team and our Trust.

An expert by experience perspective: Colin Mattinson, Greater Manchester West – The Recovery Academy

As someone that was diagnosed with emotionally unstable personality disorder three years ago, I still find it difficult to understand how my recovery has come so far in a very short time. Previously, I had spent most of my life either in education, working for bluechip companies or, later on, retraining in traditional Chinese medicine. I earned a good salary and was a productive member of the teams in which I worked, yet my life was a mess. People would come and go so fast that I couldn’t keep up. With the inescapable feeling that I didn’t relate, belong to or understand the world, I was often isolated. I figured I must have been a truly terrible person and was getting exactly what I was worth. I numbed with drugs and alcohol and found comfort by bashing my head against brick walls, but I was coping. Until my brother committed suicide. It was then that my life really fell apart and my journey began.

At 35, I was referred to a clinical psychologist. Although the therapy was painful, I enjoyed the opportunity to talk through my difficulties and build insight into how my thoughts, relationships and behaviours were contributing to the chaos. Armed with new strategies, I left therapy. It didn’t last long. I was fine until I got involved with other people at any level and then things would deteriorate rapidly. I was referred for mentalisation based therapy, an intense therapy which focused on how my lack of awareness for other people’s thoughts and feelings was creating
problems. It was a difficult pill to swallow. Only in hindsight do I realise how much I benefitted from it. Again, despite having even more armour and strategies, things still went awry. Around this time, I discovered the GMW Recovery Academy (a Recovery College, see Perkins et al., 2012) and attended their KUF for ‘Working with Personality Disorder’ training. It covered areas such as attachments, schemas, acting out, and boundaries. I soon discovered, according to mental health staff also on the course, that I was becoming a ‘revolving door’ and ‘a drain on resources’ that was nothing more than ‘a lost cause’. Years of staff resentment, frustration and experience with personality disorder meant nobody would speak to me at break or lunch. I realised that to them I was the unpredictable borderline. ‘Classifying and categorising do little to increase open communication, tending to reassure and confirm difference’ (Barnes, Ernst & Hyde, 1999). I finished the course and had a mini meltdown as a result. I did the ‘Train the Trainers’ course and expected the same attitudes. I was very wrong.

The group was populated with professionals that genuinely cared about how best to help someone recover and how best to work with and support them. It seemed to me that instead of asking, ‘How do we get these people to get better and out of my life?’ they asked, ‘These people want to grow and develop, so how can we let them?’ For the first time in my life, I felt okay to be me. The (predominantly) clinical psychologists I was working with were able to offer me a greater understanding of who I was, just by virtue of delivering training with me. Rather than thinking, ‘He isn’t trained’, they accepted my life experiences as the training. The dynamics I had been used to changed dramatically. Suddenly, I was being asked simple but important questions such as ‘What do you think?’ and ‘Do you have anything to add to that?’ There was a genuine interest in my thoughts, something that I hadn’t really had much experience in, having come from a large family. We did not have mind-minded parenting where ‘children are helped to understand that they have an inner experience that is unique to them and different to those of other people’ (Howe, 2011). Feeling valued, included and respected was all new to me, but I felt as though I belonged somewhere. ‘Belonging is somewhere where you want to be, and they want you’ (Brown, 2012). Instead of hoping I would leave soon, they gave me dates for future work, offered me additional work outside of the Recovery Academy and asked how I was feeling at the end of the work. Although emotionally demanding, the support I was given meant I was able to widen my comfort zone and develop confidence and resilience in myself. It was an uncomfortable process, since my own experiences were based on punitive attachments. As a child, my needs and feelings of vulnerability were often met with anger or ignored, and my ‘vulnerable self felt abandoned in times of need’ (Howe, 2011). Here is where the challenge of therapy begins, and why it sometimes only works for short periods and patients become the ‘revolving door’: it doesn’t account for the relatives and caregivers that are still in our lives and continue to behave in the same ways that led to our insecure attachments. No matter how much work we can put into a client-therapist relationship, there aren’t any positive role models for us to look to outside of that relationship. Worse, endeavours to use the new strategies are often met with anger, rejection or punishment, so we are soon worn down and left feeling like we are getting it wrong again. Re-referrals are made.

In the co-production model, these positive role models are ever present. We have the chance to practice new skills and experience what they look and sound like when done helpfully and kindly. Mentalising is a crucial element that is demonstrated consistently and helpfully, not misused. In the presence of clear boundaries, interactions and mentalising become easier and talking about our experiences become less emotional. Problem solving is learnt so that we feel competent and can regulate ourselves easier, so re-referrals are less likely. Moreover, in the absence of a therapeutic relationship, aspects of a professional’s personal life are shared, such as holidays, hobbies, stresses and aspirations. This is an important part in recovery. It encourages
us to think about ways to stay healthy and helps us realise that stresses are part of the human experience, not the shameful mental health experience. It affords us the space to accept ourselves, to know that everyone has the same problems, some just have better ways of dealing with them.

**Conclusion**

The idea that co-production can be clinically helpful in fostering recovery in mental health settings is relatively novel and requires empirical research. These personal accounts of EBEs and EBOs lend anecdotal evidence to the idea that working together and having opportunities to understand each other’s minds (mentalising) in meaningful interactions and meaningful relationships may be therapeutic for the organisation, professional and service user. Formal attempts to evaluate these outcomes will be an important next step.

The benefits of co-production are broad. Developing and maintaining positive working relationships has training benefits for EBOs and may benefit EBE recovery, and improve their own knowledge base and understanding of service and training delivery. Some EBEs may wish go on to deepen their knowledge or become formally trained, or their experience may create opportunities for employment. The relationship promotes joint decision making and self-management. EBEs have reported the wish to ‘give something back’; being in a position of responsibility and accountability alongside mental health providers fosters recovery and contributes to the core economy in reciprocity. The impact of co-production may also extend to the delivery of peer support groups within the third sector. Such initiatives can tend to be user-led or distanced from mainstream mental health services. These have their place, of course, but certain groups may choose to adopt co-production, just as certain services have moved toward this from an EBO-led model. This may ease relations between mental health services and the third sector.

Co-production offers a pragmatic and compassionate approach to delivering mental health services and has the potential to greatly benefit mental health professionals, the organisation providing care, and consumers. The equal relationship can be thought of as the ‘golden thread’ of co-production. The theoretical models of attachment and mentalisation may also offer frameworks to the processes that underpin this realisation.

Caution should be taken, however. For co-production methods to be implemented well and sustained over time with fidelity, strong leadership will be required – sometimes, in the face of challenges (conflicting attitudes or opinions, for instance). The co-production approach does not suit everyone. Some may enter into the relationship with a misunderstanding or rejection of its core principles. These attitudes and assumptions can be very subtle. Co-production may not facilitate recovery for all users. Research to identify the factors involved for those who benefit is needed. The approach may require a certain level of self-awareness, stability and motivation to commit to and undertake the work. It is possible that those who have never been in employment and do not have experiences of non-damaging, mentalising relationships may find it harder to adjust to the approach.

Building on the emergence of co-production in recovery colleges by bringing it into everyday business can help the organisation provide more recovery-focused interactions. Supporting an ethos of listening to, working with, and empowering the service user, rather than the traditional ‘do to/for’ approaches can lead to better recovery, and co-production could be a powerful method of addressing traditional organisational culture. Any form of mental health care/treatment/support is more effective if carried out together.

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Clinical Psychology Forum 268 – April 2015
"RECOVERY" has become the dominant idea in UK mental health policy. While it has become an important framework for national action and analysis, it is also an international idea. It is difficult to be precise, but its origins seem to lie in the US. When I googled mental health recovery, I got 102 million results (accessed 21 July 2014). At the top were entries from lead UK mental health charities, Mind, Rethink Mental Illness and the Mental Health Foundation – a sign that the idea has widespread support beyond policymakers. Also appearing in the top five listed, is Wellness Recovery Action Plan (WRAP, which is copyrighted). WRAP is a US based initiative, which describes itself as an ‘evidence-based system’ that:

…is used world-wide by people who are dealing with mental health challenges as well as medical conditions such as diabetes, weight gain and pain management, and life issues like addictions, smoking, and trauma...

www.mentalhealthrecovery.com
– accessed 21 July 2014

There are now ‘recovery colleges’, a large and rapidly growing recovery literature, recovery courses, leaders, experts, consultants, advocates and research. However, we also know that recovery is a controversial idea. It has gained widespread support from different stakeholders, including mental health commentators, professionals, service users and family carers. But it also has critics among all these constituencies, including this author. Reservations raised are less to do with the essential definition of ‘recovery’ than with its ideological, material and practical relations.

However, it is a concept with great power. To reject the idea that people who experience ‘mental health problems’ should be written off as incurable, permanently damaged and ‘irrecoverable’ would be a difficult position to hold. First, it would require fortune-telling skills that none of us can reasonably claim. Second, it would be a little like attacking ideals like ‘mom’ or ‘apple pie’, since who could possibly object to an something ostensibly as positive and anodyne as wanting people to ‘get better’? This has always been one of the great strengths of the so-called recovery movement. In principle there seems so little to object to. Doing so can quickly seem cynical and mean-minded. However, before we take on ideas that actually affect the lives of millions, we do perhaps need to be a little more rigorous and demanding of them than this.

To begin with, let’s take a couple of steps back, beginning with the unstated assumption underpinning ‘recovery discourse’. First, for all its many fundamental flaws, the old psychiatric system, even in its Poor Law days, did not universally assume that service users were ‘irrecoverable’. Some people tragically were kept in asylums all their lives. Many were not. This is not to understate the awfulness of the old lunacy system; it is simply to make the point that the notion of recovery is not necessarily such a new thing or a big deal. The mental health charity Together, for example (formerly MACA; the Mental Health After Care Association, founded in 1879), is proud of its Victorian founder, the Reverend Henry Hawkins, who was committed early on to the idea that people from asylums could be placed in jobs and back in the community to lead ‘a normal life’ (www.together-uk.org/about-
us/our-history, accessed 22 July 2014). So much for this being viewed as a twenty-first century innovation!

There is no single definition of recovery, but there are strong similarities in those which have come into widespread use. There is talk of the ‘recovery journey’ being ‘individual’ and associated with ‘themes’ like hope, acceptance, control, basic needs and meaningful activity (Rethink Mental Illness, 2011). The emphasis is very much on ‘self-management’, ‘having full control’ over your life, ‘optimism’, and fostering ‘abilities, interests and dreams’ (www.mentalhealth.org.uk/help-information/mental-health-a-z/R/recovery). In other words, definitions are vague, unclear, value-laden, and emphasise personal change. What is interesting is that this idea of ‘recovery’ has come to prominence when it has. There is widespread agreement that the UK mental health system and mental health policy are currently in crisis. Not only has already inadequate funding been further cut, as part of the Coalition government’s ‘austerity’ policy, but mental health service users have also experienced unprecedented restrictions and cuts in welfare benefits, undermining their security and raising levels of stigma, fear and anxiety (O’Hara, 2014).

As one high profile mental health campaign, the Campaign to Save Mental Health Services in Norfolk and Suffolk, has pointed out, the impact of government mental health policy changes has been devastating. They report people in crisis waiting up to eight hours for an ambulance. Because of cuts in local beds, mental health service users are being sent all over the country, sometimes to costly private hospitals. People are not receiving their personal budgets, a flagship government policy, because of cuts in services. Patients who had remained well with outreach services, are now coming back in need of help because these have been cut back. As local MP and Care Minister Norman Lamb was launching a ‘Mental Health Crisis Care Concordat’ the campaign was highlighting that over a period of five months in 2013, there were 22 unexpected deaths among mental health service users (www.norfolksuffolkmentalhealthcrisis.org.uk).

At first glance it is difficult to see how ‘recovery’ can be a sustainable policy under such conditions. How is it likely that people experiencing distress will be able to overcome exclusion, regain their confidence and approach the world and their situation with ‘optimism’ when services are being reduced and their own networks of support may be being undermined by the threat of losing their home or pressures to move because of new restrictions on welfare benefits? This, however, ignores a central feature of the policy and concept of ‘recovery’ – its essential ambiguity. This point has been explored in detail by the Canadian academic, Marina Morrow, in the context of ‘mad studies’, where she raises the question of whether ‘recovery’ is a ‘progressive paradigm or neo-liberal smokescreen’ (Morrow, 2013).

Recovery, as has been rolled out by government and policymakers in the UK, highlights many of the problems and tensions highlighted by Morrow. For all the social and humanistic rhetoric associated with it, the term ‘recovery’ is inherently one that originates in medicalised thinking. It is essentially based on a medical model: ‘getting better’. Thus, unlike the idea of ‘independent living’, pioneered by the disabled people’s movement, which took account of disabled people’s ongoing need for support to enable them to live alongside non-disabled people on as equal terms as possible (Barnes, Oliver & Barton, 1997), recovery suggested that it would be possible to withdraw support as people ‘recovered’. This ignores the reality for many mental health service users/survivors that their need for help and support may be varied, continuing or recurring.

The associated emphasis on ‘reablement’ has encouraged a notion of ‘throughput’ in services, with support withdrawn when people are regarded as sufficiently ‘recovered’ rather than its importance being recognised in maintaining their well-being. This of course fits well with policy concerns to
reduce services and support. It has also fitted well with government welfare reform policy committed to getting people ‘off benefits’ and into employment. Increasingly, a key criterion of recovery has been people entering or re-entering employment, with little consideration given to the nature, quality or suitability of such employment (Harper & Speed, 2012).

It would be a mistake, however, to see or treat ‘recovery’ as an isolated example of policy and terminological ambiguity. We would do well here to heed the wise words of George Orwell, when he wrote about the degradation of the English language in relation to politics (Orwell, 1945). In the UK we can see a large range of modern policy developments similar to ‘recovery’ which share the same characteristics. What is interesting about them, is that often they can be seen as progressive ideas, that are then colonised and subverted by policymakers to serve very different purposes. This helps explain both their ambiguity and their capacity to gain support from service users and citizens, even if they may not ultimately serve their interests. That is to say, they may have:

- liberatory origins;
- originated from citizens, patients and/or service users;
- gained support from grassroots constituencies; and
- are framed in terms of emancipation, independence, empowerment, choice and control.

Yet all can similarly be seen, as they are implemented, to serve neo-liberal aims and be consistent with its ideology. This is true, for example, of:

- ‘Patch and community social work’ – presented as reducing bureaucracy and state control, but ultimately seeking to colonise community networks and rely on women’s unpaid responsibilities as ‘carers’ (Beresford & Croft, 1986);
- ‘Personal budgets’, originating in the direct payments developed by disabled people, but reconceived as a voucher system, associated with cuts in funding and collective services (Slasberg, Beresford & Schofield, 2013);
- ‘Social inclusion’, drawing on progressive European terminology, ostensibly to support people’s inclusion in mainstream life but increasingly associated with being required to be in employment, signifying people’s individual irresponsibility if they are not, rather than challenging the social and economic barriers they face (Levitas, 2005);
- ‘Welfare reform’, originally used to mean challenging inequality and reducing poverty and disadvantage, now used to restrict access to financial support and force people into employment.

We can see this reconceptualisation of progressive ideas and initiatives as a characteristic of modern neo-liberal social policy.

The medicalised origins of ‘recovery’ highlight another key problem associated with the policy and concept. In 2009, three of us, as survivor researchers, reported the first phase of a project exploring mental health service users’/survivors’ views about the conceptualisation of distress and mental health problems (Beresford, Nettle & Perring, 2009). What came strongly out of this research and reinforces findings from other studies and consultations, is that survivors think that the dominant model underpinning understandings of mental health problems is a medical model. They think it is this model that dominates professional, public, political, policy and media understandings. More importantly, they feel that it is a damaging model; a damaging basis for interpreting and responding to their experiences and issues. They feel it isolates and pathologises them – searching for what’s ‘wrong’ with them. As a result, it inherently stigmatises, reduces and dehumanises them. This is also confirmed by yet unpublished findings from the second phase of the project.

This project and other more informal discussions suggest that mental health service users feel that social understandings are much more likely to be helpful and this reflects the growing interest more generally in such models (Tew, 2011). However, psychiatry continues to be the dominant profession...
in the context of ‘mental health’. It is essentially and unapologetically a medical profession. Like the rest of medicalised structures it still rests on a strongly hierarchical culture and set of structures; from the consultant at the top, to the nursing or social care assistant at the bottom.

We should not deny the structured dominance of a medicalised model. This has been associated over the years with the emergence of a growing list of psychiatric diagnostic categories, incorporating an ever-widening range of phenomena, emotions, behaviour and experience, as the world which psychiatry has adopted subject to its authority has massively expanded. This is not a criticism of any individual psychiatrist, or indeed mental health worker. It is a critique of psychiatry, which has long been developed and evidence of anomalous medical dominance in the conceptualisation of mental health issues and of responses to mental health services. Such psychiatry has been exported internationally – globally, to poor third world countries. Its power is enormous, but as we have seen decade after decade, its capacity to reflect and respond helpfully to experience and emotions has been constantly questioned (Burstow, LeFrancois & Diamond, 2014).

There is, however, a more recently identified issue that also needs to be highlighted and explored in the context of ‘recovery’. This is the often informal and sometimes formal alliance that has developed between neoliberal ideology and psychiatry. We live in an age of global neo-liberal politics and ideology, where the aim has been to reduce the state and the support it can offer to people, and instead to turn to and prioritise the market. This has resulted in the redistribution of wealth and power to the rich and powerful and the privatising of arrangements for help and support that were once public and state supported. We have been seeing this shift to neoliberalism continue in the UK from Mrs Thatcher to the present, but with greatly renewed energy since 2010 and the coming to power of the UK coalition government, and this is also now strongly associated with the privatisation and outsourcing of mental health services and support.

‘Recovery’ provides an excellent example of the working of this alliance. We should remember, as has been shown, that it is not an isolated example, and that the ambiguity that surrounds it is a feature of such policy developments under neo-liberal politics and ideology. On reflection, it is easy to see how an alliance between neoliberalism and psychiatry makes great sense for them both. Neo-liberals tell us we are individual consumers and not to rely on the state, but to stand on our own two feet. Psychiatry is framed in terms of individualised explanations for our emotions, experience and behaviour. Biography and history are dislocated. Social problems are reduced to personal shortcomings and increasingly become diagnostic categories for psychiatry to exercise the lead role in. This is the logic of psychiatry under neo-liberalism. It is part of a system of individualisation that drives towards greater and greater social injustice. All the evidence suggests that neoliberalism, with its push to inequality, to increased poverty, to disempowerment, to division and international conflict, is bad for people’s health – their physical and mental health. It doesn’t even seem to be good for the health of those who seem to profit from it – a point made in The Spirit Level: Why equality is better for everybody (Wilkinson & Pickett, 2010).

While some service users have aligned themselves with the philosophy of ‘recovery’ and clearly hoped that it could help them achieve improvements, both individually and collectively, the dominant neo-liberal definition, with the power of governments and policymakers behind it, seems to undermine their aspirations. However, a more promising, far less ambiguous development is also now taking place that may offer much more hope for the future than ‘recovery’.

This was signalled most clearly by the publication in 2013 of the Canadian book Mad Matters (LeFrancois, Menzies & Reaume,
Canada particularly has been taking forward discussion and action on what it has unambiguously called ‘mad studies’ and now the idea has reached the UK and is developing as an international movement. This substantial book is one that may make it possible to move beyond the dominance of psychiatry and the current alliance between psychiatry and neoliberalism, and at last find a more helpful way forward out of distress, madness and mental health problems.

What is particularly valuable about Mad Matters, and why it can perhaps make a real difference internationally, is that it offers a way of melding insight and understanding with making change. Here is ‘praxis’ and ‘conscientisation’ as the radical social reformer Paulo Friere would understand and argue for them (www.wikipedia.org/wiki/Paulo_Freire). The struggle of mental health service users/survivors against the damaging effects of psychiatry has often seemed a lonely and difficult one. But this book demonstrates that people with direct experience, supportive professionals, academics, educators and researchers can together take forward mad studies and mad action. In the book, no one speaks for others, but instead offers their own different contributions and understandings, from their experience and from working together. And here we can see the value, the strength and the possibilities of such alliances.

Survivors have made it clear that they do not want yet another dominating explanation or set of ideas imposed on them, or to risk imposing them on themselves (Beresford, Nettle & Perring, 2009). At the same time, as we have seen, they value more social approaches to their situation and experience. Mad Matters takes us further forward in this search, by bringing so many strands of critique from non-medicalised perspectives together. In doing so, it helps reclaim the important but devalued idea of madness, exploring the history, culture and language of madness and mad people. It highlights the diversity of mad experience and understandings, the damaging effects of psychiatry, the ambiguity of its reformism and the emergence of survivor research and academic engagement. Here is a real prospect of a positive alternative to the ambiguity of ‘recovery’ as a driver both for survivors’ struggles and public policy.

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Traditionally, severe mental health difficulties were regarded as ‘chronic’ and individuals were considered to require lifelong support, frequently resulting in incarceration in asylums. In more recent history, ‘continuing care’ services expected to work with service users for the long-term and discharge was not a priority.

The recovery model came to prominence in the late 1990s and represents the belief that people with severe mental health difficulties have the capacity to recover and may not become a ‘chronic patient’. Recovery has been described by those who have achieved it as a unique and individual journey of personal growth (Ridgeway, 2001). Recovery may involve the development of a positive identity and outlook for the future, fulfilling activities and a purpose in life, meaningful social connections, and accessing the right treatments and supports for each individual (Brown & Kandirkirira, 2007). Recovery may occur even with the presence of ongoing psychotic experiences ‘Recovery might mean living with the presence of distressing symptoms yet coping with them and living well’ (Cupitt, 2010, p.215).

For some service users, achieving recovery may mean that they no longer require intensive support services such as assertive outreach or rehabilitation teams, and can be discharged to a less intensive community based teams, such as a recovery team. For others, recovery may eventually mean they no longer require the support of any mental health services and can be discharged back to their GP. However, there may be another group of service users for whom achieving recovery and maintaining a good quality of life may require the continual support of mental health services.

As the recovery model swept through NHS mental health services, some teams were given guidance about the length of time they were expected to work with service users; for example, two years in an early intervention or recovery team, one year in an assessment and treatment team. These guidelines may be appropriate for some services users and longer engagement with services may inadvertently hold them back from engaging with their local communities or finding work. However, other service users may require lengthier support and premature discharge may result in relapse and a readmission in crisis. This can be very distressing for the service user and their carer, and may set them back in their recovery journey. The aim of the current piece of work was to highlight factors drawn from an individual’s history and current life situation that may guide mental health profes-

This paper proposes factors that may be important to consider when thinking about the length of stay and/or considering discharge of a service user with severe mental health difficulties from a community team. The paper contains the views of service users on the factors proposed.

...achieving recovery and maintaining a good quality of life may require the continual support of mental health services...
professionals when considering the length of support an individual may require.

**Formulations and trends**

This piece of work was carried out at the Greenwich Assertive Outreach Team. In order to formulate which factors may be helpful to consider, an extensive review of medical notes was performed, with particular attention to the individual’s background, childhood history and mental health history. Notes of clients the team were planning to discharge were scrutinised. They were then contrasted with the records of clients the team had no current plans to discharge and required a high level of ongoing support. A third group was also addressed: clients who came to the Greenwich Assertive Outreach Team by virtue of their forensic history and the monitoring that was felt necessary.

Trends that appeared to distinguish between clients who may be discharged and clients who appeared to require longer support were established. The development of these factors was informed by the psychological and psychiatric literature on recovery. The factors were then separated into historical and current. Historical factors represent aspects of a person’s history that cannot be changed; for example, childhood abuse or neglect. Current factors represent aspects of the person’s current life situation. Identifying current factors highlighted interventions which could promote an individual’s recovery and therefore guide care planning.

It is important to note that these factors do not represent definitive predictors of recovery. Rather, they may be employed alongside clinical judgment in guiding clinicians’ thinking and the development of care plans. Additionally, the relative contribution or ‘weight’ of a given factor is not prescribed. Different factors may be more relevant to different clients. Again, clinical judgment will inform the importance of the different factors for an individual client.

**Historical factors**

**Attachment**

Disrupted or insecure early attachment is related to adult mental health difficulties (see, for example, Drayton, Birchwood & Trower, 1998). Similarly, secure/adequate attachment contributes to resilience in adulthood. Adequate early attachment may mean a client is more able to move on from services. Disrupted attachment (e.g. parental death, parental absence, boarding school) may leave a person vulnerable in adult life and requiring ongoing support.

**Upbringing**

It appeared that those clients who were more likely to move on from services had a more stable childhood and upbringing. Instability (e.g. several moves between different countries or within the same country, parental divorce and step-families, parental hospitalisa-
tion) appeared to be associated with higher support needs in adulthood.

**Childhood abuse/neglect**
The experience of emotional, physical and sexual abuse or neglect in childhood is related to mental health difficulties in adult life (Varese et al., 2012). Those who experienced more severe childhood abuse/neglect appeared to have greater trouble managing their adult life and required more intensive support. Absence of, or less severe, childhood abuse and neglect was seen in the clients who were moving on.

**Learning disability**
Some clients were diagnosed with a learning disability in school. For others, neuropsychological assessment may reveal the presence of a learning disability. Those clients with a learning disability in addition to their mental health difficulties may be likely to require ongoing support.

**Achievement of life goals before onset of mental health difficulties**
Those clients who were moving on appeared to have greater achievement in their life goals before they had first come into contact with mental health services. Life goals could be broken down into three domains:
- **Education** – attendance at school, gaining qualifications;
- **Employment** – ability to gain and maintain adult employment;
- **Relationships** – ability to form and sustain friendships and intimate relationships.

**Timing of onset/need for services**
Those clients who needed support from statutory services earlier in life were more likely to require ongoing support in adult life. For example, some clients were seen by child and adolescent mental health services throughout their childhood. Other clients experienced the onset of psychosis early in their adolescence. In contrast, those clients who did not require support from services until later in their adult lives were also more likely to have achieved life goals before the onset of mental health difficulties and appeared more able to move on.

**Sudden vs. insidious onset**
An argument can be made from the literature that those individuals who experience a sudden onset of psychosis are more likely to achieve a better recovery. Individuals with acute onset generally have a more favourable outcome than with an insidious onset (Sartorius, Jablensky & Shapiro, 1978). The shorter the duration of untreated psychosis, the better chance there is of a good outcome at two years (Keshavan et al., 2003). Additionally, outcome at 15 years may be best predicted by the period of time spent experiencing active psychosis in the first two years (Harrison et al., 2001). Individuals who experience a sudden onset may spend less time actively psychotic and have greater chances of achieving recovery.

**Current factors**

**Dependency on Services**
Some clients were more dependent on the team to help them manage their lives. They approached the service for help with benefits and housing. They were escorted to their GP or hospital appointments. Additionally, some clients did not want support, but struggled to manage their life circumstances and suffered the inevitable consequences: frequent evictions, disruptions to their benefits, decline in physical health. These clients appeared to require ongoing support. Alternatively, some clients did not expect help from the team. They attempted to manage their lives independently, and perhaps only needed support in very difficult circumstances. These clients were more likely to be in the group preparing for discharge.

**Ability to separate from caregivers/services**
A developmental stage that faces adults in Western society is the ability to separate from parents and/or caregivers (Erikson, 1959). Some clients struggled to separate adequately from their parents. Their parents may be over-involved in their lives; for example, making decisions for them. This may hold clients back from progressing in their recovery. For example, a father who was anxious about his son’s past suicide attempt held the son back from commencing voluntary work in case he became stressed and
relapsed. The ability to separate from parents is likely to reflect the client’s capacity to separate from mental health services and move on in their lives.

Support network
Clients who had an adequate support network outside of mental health services were more able to progress in their recovery. This support may come from family, but friends and the wider community were also very important. Clients who were actively involved in (voluntary) work, sporting activities involving socialisation, religious life, college, service user involvement projects, parenting groups/schools were less likely to require high levels of support.

Substance misuse
Substance misuse is related to frequency of relapses in psychosis (Gupta, Hendricks, Kenkel, Bhatia & Haffke, 1996). Serious substance misuse may also interfere with an individual’s ability to manage their life. They may spend their money on obtaining drugs and omit to pay essential services bills or rent/mortgage and be evicted. They may allow their property to be used a venue for taking and/or dealing drugs and again face eviction. As such, those clients who misused substances were more likely to have a need for ongoing support.

Current cognitive functioning
Research has shown that active psychosis, antipsychotic medication and substance misuse can affect cognitive functioning (Simonsen et al., 2011; Solowij, 1998; Weinberger & Gallhofer, 1997). Clients may have other life experiences that compromise their cognitive functioning; for example, head injury, HIV, stroke. Clients with compromised cognitive functioning are likely to require continuing support.

Future expectations
Some clients may have realistic plans and goals for the future. However, others may have unrealistic (possibly delusional) plans or have few expectations for the future. They may feel that their mental health difficulties have ruined their life and they would not be able to achieve anything in the future:

When I was discharged, I was living with my sister in a council flat. I was 22 years old and I lost all hope that I could make it in life. I thought that I would not be able to work or go to school. (Colbert & Peace, 2012)

Higher expectations for their future lives were found in the group of clients that were preparing for discharge.

Salient risk
Some clients have a history that includes a significant risk factor. These may include a dramatic or very serious suicide attempt, significant violence, potential involvement in terrorist activities, carrying weapons, fire setting, harm to children, risk of heart attack/stroke from obesity and medication. The anxiety in mental health services and other agencies (e.g. police) about the possibility of these risk incidents reoccurring may mean that services inadvertently hold these clients back from moving on in their recovery.

Future directions
This work was presented to several teams who work with clients with severe mental health difficulties. The staff found it helpful to highlight such factors and gather them in one list. This gave additional guidance and clarity to their client reviews. There are plans to formulate a tool to assist in discharge planning based on these factors.

In order to validate the factors suggested above, a large piece of research could be undertaken investigating the pathways of clients with severe mental health difficulties through NHS services over a number of years and any association with the factors presented above. Such research may also be able to determine whether specific factors could be given more weight (i.e. seemed more influential upon recovery than others).

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Throughput trends

References

Service User Review by Trudy Angus, Member of ResearchNet Greenwich

ResearchNet (www.oxleas.nhs.uk/your-views/patient-experience-programme/researchnet) are a mixed group of service users, carers and professionals interested in researching all aspects of mental health and mental health services.

As a service user who has gone through the recovery system recently, this study is most welcome. Had something like this been in place when I was being treated I could possibly have been discharged earlier and with a more positive outcome at the time.

The first question I asked myself upon reading this was: ‘Would this have helped me as a service user?’ My answer was, ‘Yes, especially if I had been made more aware of the current factors that could help or hinder my progress and so influence my recovery.’

This potential tool would provide all members of the team with a structured format to work with and could in the future help prevent service users from falling through the net, either by being trapped in recovery services or by being discharged prematurely.

The clear simple explanations of the various factors both historic and current help to provide clarity and provide useful indicators as to why some service users might not be doing as well as could be expected, which could then be used to create a more effective treatment plan for the individual.

It’s true, having a chronic mental health condition doesn’t necessarily mean that lifelong support is needed. This study and the proposed tool for discharge could, it would seem to me, provide a framework to allow professionals and service users to better collaborate to potentiate more positive outcomes resulting in service users requiring less or even no support by gaining more confidence and ultimately independence.
Recovery: Accepting the unacceptable?
Bethan Mair Edwards

As an influential and dominating discourse of lived experience, recovery has significantly impacted perceptions of what best practice in mental health should constitute (‘recovery is for all’), and is frequently purported as a lifelong journey or process (SLAM NHS Foundation et al., 2010, p.1). But can something advocated as deeply personal be meaningful for all, for life?

Recovery’s ‘shared’ values, vision and outlook are popular and prevalent and have become paradigmatic in name and nature (Slade et al., 2014). Indeed, as third sector, statutory and independent mental health services become recovery-oriented, a priori notions are prevalent that recovery is the most valid reflection of reality for ‘all’ individuals with lived experience, providing the most appropriate ‘conceptual framework’ within which to deliver care and support (Leamy et al., 2011, p.1). However, whilst recovery is firmly advocated as a process whereby people with lived experience build a personally meaningful life, its pre-determined universality is inconsistent with the ‘distinctively human’ and deeply personal process of meaning-making (Krauss, 2005, p.762). Indeed, as a process of understanding, making sense and interpreting our experiential reality, meaning-making is ongoing, personal and contextual (Krauss, 2005).

The age of austerity’s cutting culture has enabled welfare reform and service closure to accelerate at people with lived experiences’ disproportionate expense. Recovery’s shared values, including hope, optimism and acceptance have the potential to deeply invalidate the present and historical injustice that people with chronic and serious mental illness experience most acutely. In a culture enforcing the acceptance of the unacceptable, recovery’s emphasis upon personal responsibility and innate potential to experience recovery, grossly underestimates the power of context beyond an individuals’ ability to influence or change. Slade et al. (2014) express concerns regarding the generalisability of recovery in collectivist non-Western cultures, yet fail to acknowledge that recovery may not be generalisable within individualist cultures, in desperate need of collective responsibility and action. Positive thinking will not fulfil Maslow’s hierarchy of needs, neither will it prevent the most unfortunate hanging onto the purse strings.

In a system that systematically and legally confines and removes rights, pre-defining and determining current and future experience irrespective of personal preference or context may further alienate people with lived experience from their experiential reality (Laing, 1967). Indeed, whilst recovery may be meaningful for many, it fails to embrace the diversity and plurality of human experience throughout the life course popular (including lived experience not conceptualised or experienced as recovery). Not only do commonly utilised recovery outcome measures quantify a deeply personal narrative, they provide the framework upon which an individual’s experience is interpreted, measured and diagnosed, perpetuating the notion that recovery is for ‘all’.

Despite its power to invalidate and alienate, and with questionable rigour, anyone can diagnose a lifelong recovery based on a single characteristic – mental distress. Indeed, paralleling concerns regarding the validity of psychiatric diagnoses, the paradigmatic nature of recovery is based upon assertions that recovery is ‘at least relevant’ and based upon a ‘less developed’ evidence base for mental health conditions other than psychosis (Slade et al., 2014, p.13). Pathologising an aspiration shared by many the world over, recovery may disable rather than enable people with lived experience to live a meaningful life ‘beyond’ mental illness (MHF, 2014).
Indeed, labels stick and recovery makes no secret about this – it’s for life.

The manner in which recovery has ‘translated’ into working practices has frequently been in accordance with the views, values and agendas of those who obtain the power to implement and influence such changes. Indeed, as personal experiences, services and organisations are rebranded recovery, entire caseloads or populations of people with lived experience are overnight universally and potentially impersonally and unbeknownst to them ‘in’ recovery. This is not personalised care, neither is it the beginning of a meaningful life. Furthermore, in contrast to recovery’s emphasis upon empowering through choice and control (Leamy et al., 2011), services that provide all support within a recovery ethos may exclude those who do not ascribe to its values from personally meaningful support. Used in this manner, recovery may not be an active process, but a purely prescribed and passive one with few choices: recovery becomes the knowledge of services, to be learnt by those with lived experience in a Recovery College. Whilst it is possible to ‘understand’ or ‘learn’ recovery, no one can make you feel, believe or do recovery meaningfully.

Sadly, for those of us with lived experience, recovery has now moved beyond the personal to the corporate and commercially meaningful. Recovery-focused outcome measures now form the basis upon which services are paid and contracts maintained, with recovery providing those traditionally in power with a powerful rationale to cost-cut in the name of ‘recovery’. Becoming the accountant and auditor’s concern, numbers and bank balances overlook the personally meaningful and personal tragedy of losing a service that has enabled many to live a personally meaningful life.

Having permeated systems, organisations and cultures that are fundamentally at odds with its original values, from survivor led beginnings, recovery is now a prolific paradigm. ‘Brand Recovery’ is powerful, and as such it empowers and disempowers. Portrayed as its antithesis, reflection upon the medical model’s heyday and hangover is necessary when considering recovery’s paradigmatic nature today, including hierarchies, power-relations and prescriptive, paternalistic and diagnostic practices. Whilst well-meaning, indiscriminate proclamations that recovery is for all fail to value or acknowledge people with lived experiences’ capacity and right, like everyone else, to make meaning in the context of their diverse experiential realities. Removing the right to frame experiences and receive services in accordance with what is personally meaningful invalidates, alienates and excludes. It is essential that the recovery movement embraces diversity and accepts that without concerted action to address its capacity to disempower, in addition to the context within which itself and individuals with lived experience exist, recovery cannot be meaningful for all – no one should accept the unacceptable.

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References
Poetry for recovery: Peer trainer reflections at Sussex Recovery College

Tessa Martina

To see a World in a Grain of Sand
And a Heaven in a Wild Flower,
Hold Infinity in the palm of your hand
And Eternity in an hour.
(William Blake, 1803)

PEER TRAINERS contribute a personal or lived experience of mental health and a training qualification in paid employed posts within NHS Trusts (Skills for Health, 2011). Over the past eighteen months I have co-facilitated courses with mental health professionals on different topics at Sussex Recovery College. The pilot programmes have provided many exciting challenges, the most rewarding course has been ‘Poetry for Recovery’, part of the Well-being Strand from the college prospectus.

Evaluating and reflecting is part of the process of a trainer and practitioner; one I am familiar with after twenty years in education and as a practising artistic therapist before lived experience of mental health changed a full-time career and focus. The six-week course ran with a three week break in the middle. The Sussex Recovery College’s West Sussex Prospectus Autumn 2014 (Sussex Recovery College, 2014) outlines the aims and objectives agreed by the co-facilitators, with a focus on what students will get from the course:

‘Students will:

- Share personal experiences, associations and relationships with the style and content of the poems and prose.
- Find a new way of using one of the following skills in creative expression: sound; image; words; collage or movement.
- Participate in group exercises to write individual and group poetry and prose.’
(Sussex Recovery, 2014, p.22)

The student evaluation gathered before a course includes generic individual learning plans, with a self assessment form adapting the Warwick-Edinburgh Mental Well-being Scale, with specific course feedback on the final session. Further evaluation will be possible next term when we strengthen the number of people completing the forms at individual learning planning meetings. This article focuses on the ‘Poetry for Recovery’ statistics and students comments within the specific forms, collated by Emogen Campbell, an assistant psychologist. It aims to integrate personal trainer evaluation on what worked and how it could be improved to consider why ‘Poetry for Recovery’ was successful from a Peer Trainer perspective, and whether these elements are transferable to other courses.

Eight of the twelve students attended regularly with 64 per cent mean overall attendance, which falls within national averages; all of the students had lived experience of mental health; 37 per cent were from non-English heritage; all 12 students thought the course was excellent. Comments included:

Most helpful –
‘The support and encouragement from the tutors really boosted my confidence in my ability to write.’
‘A safe environment to write and read poetry.’

Could improve –
‘A longer course! So enjoyable.’
‘No idea – I enjoyed it just as it was.’
The variable elements of the comparative course for a Peer Trainer include the students, co-facilitators, topic and content. The learning outcomes were flexible, encouraging people to enrol for diverse reasons (sharing mental health issues; a diversionary activity; starting a new activity; being creative; meeting new people; and developing an existing interest).

Both facilitators were nominated by a steering group, as poetry is appreciated as a healing power of language (National Association for Poetry Therapy, 2014) for people with lived experience of mental health, and both trainers had either a direct connection to poetry or to other creative areas.

Each session began with ‘sharing’ or ‘ice breaker’: poetry reading from selected poets or an individual’s creation from the previous week. The structure for the group included shared stories of lived experience, daily life, challenges and celebrations. Facilitators brought a new theme each week, including imaginative exercises to engage visualisations, sounds, touch and smell, as a starting point to writing. Each week included writing opportunities for students and sometimes for co-facilitators. The sessions were wound up with suggestions for homework to maintain the focus for the week.

The role of the peer trainer is to provide elements of their lived experience related to the theme. Aspects of a psychotic experience some 18 months earlier, connected to writing and the word were illustrated with William Blake’s poem.

One hundred per cent found the training facilitated by both peer trainers and mental health professionals helpful.

To talk about a reality that is not of the ‘sense world’ yet not nonsense either is a an unusual opportunity as family, friends and professionals are often concerned that the person is returning to a time those closest to them wish to forget or divert attention from. The world of poetry is able to bridge this gap. During the breaks people would share previous ‘non-sense’ experiences too. These words would interweave into the writing.

On reflection, sharing lived experiences at this level was more personal and deeper than on any of the peer content on previous courses I had attended. On occasions, this also brought forth experiences which students had also not shared before. Student comments on feedback reflect appreciation of the approach:

A great dynamic between the two trainers; friendly, encouraging and supportive.

To build a connection within the group during the planned break of three weeks, the ‘cut up technique’ (Burroughs, 1963) was applied. For many participants and trainers this group poem became the highlight of the course. Each person shared a meaningful event from the week and then wrote an individual poem on the topic. These were read out in small groups before each line was cut into strips and a collective meaning created. With the negotiations complete, the strands were stuck together on a large sheet, the final poem was named, and one person stood to present it. The title of ‘Immigrants’ was agreed by the creators seconds before presentation (see Figure 1).

This poem caught the mood of the day, which followed the 2014 local elections with a significant increase in UKIP’s votes. There was a tangible resonance within the room, which was given space to ‘breathe’ before the group was able to move on. The bond built during this session spanned the break of three weeks in the middle of the course and spontaneously produced two small buddy groups meeting or e-mailing poetry to each other, creating support and resilience:

Enjoyed hearing each others stories, the group poem was a fantastic bonding opportunity.

Poetry enables a deep expression of soul. These inner resources include the shadow, or dark side, and owning it through expression can transform the power of negative emotions. Sharing difficult experiences through poetry brought laughter, tears and strength to the group.

Based on data from the student feedback forms, 80 per cent of the group found the
course useful or very useful in everyday life, as represented by the following comments:

'It was a lot of fun, got away from being “bogged down by mental illness”. I loved it.’

‘A better understanding of what makes a good poem, knowing anyone can write and how it can help manage moods and feelings in recovery.’

Also, 80 per cent of participants reported the course increased their knowledge and skills moderately or a great deal:

‘A huge confidence boost and a new way to express emotion.’

‘A better understanding of what makes a good poem, knowing anyone can write and how it can help manage moods and feelings in recovery.’

Additional comments included:

‘I had no idea what to expect, I came with an open mind and wasn’t disappointed.’

‘Well done for delivering an excellent course. I would love to do a similar course again in the future.’

Recovery College aims to integrate participatory recovery with course management and delivery with the freedom for students to select, attend, participate and graduate (or not) from any course. The Peer Trainer role of ‘guide on side’ rather than the ‘sage at the front’ was evident during ‘Poetry for Recovery’ and the student feedback indicates the course was a success.

Empathising with the deep connection between my lived experience, words and poetry and then sharing this with others, combined with co facilitating a structure that created a bond for the group extended personal and professional development are the elements I would like to apply to other courses. This next step is a challenge I welcome.

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Figure 1: ‘Immigrants’

Distant sounds of other humans
Lump of clay heavy in my hand
Talented, deeply feeling,
Willing to share.

Dry, brittle, fallen twigs
Crunching under foot
Dark clay no longer soft and malleable,
Hardened by time, holding a fierce grip on its treasure

Offering pieces of themselves.
Feeling of being alone, after hours
Quiet.
The same but different, each with their own challenges.
Too thin and non-descript to even cast shadows
But still standing where others have fallen.
A second chance to reach up to the sky
And be a work of art.

The ebb and flow
Humans arriving, the wounded retreating
Bare limbed
Snap of skinny, wooden arms

From the sea, rough edges smoothed off
Small but perfectly formed
A rainbow of browns and greys
Focused, insightful, prolific,
The limitless collisions of diversity
In between.
Other more vibrant things around me
But the fragility of this catches my eye

Searing pain of effort to accommodate
Rejection
And wonder why
Painful to walk on bare-foot

Boundless hope in trembling hearts
Ground down to bleeding shards
The same sky hovers over all
Many feet tread the same

Compounded earth
Many ‘brothers,’ many sisters – all part of one family.
Thoughtful, kind, unassuming yet receptive

Accepting and openly loving,
The rare glow emanating from the Harmonious waves,
Fits in the palm of my hand

Peaceful.

(Jo Harris, Roxy Mullick, Sam Turner, Janine Woodland, plus Dave Hempshall & Tessa Martina)
I am the song
I am the song that sings the bird
I am the leaf that grows the land
I am the tide that moves the moon
I am the stream that halts the sand
I am the cloud that drives the storm
I am the earth that lights the sun
I am the fire that strikes the stone
I am the clay that shapes the hand
I am the word that speaks the man

(CHARLES CAUSLEY)

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References
PEOPLE USING mental health services have long requested more information, support for self-directed care and self-management, empowerment and choice, and employment of peers in providing services (e.g. Social Care Institute for Excellence, 2007). This has driven the development of recovery oriented practice in mental health services over the past 20 years. Recovery orientation requires a focus on approaches which foster hope and the possibility of reaching personal goals and ambitions, taking back control of symptoms and life, developing valued roles and relationships, finding meaning and purpose, and having the opportunity to do what is personally valued to build a life beyond illness.

Cultural change in mental health services towards recovery oriented practice is supported by mental health policy. No Health Without Mental Health sets the objective that ‘more people with mental health problems will recover’ by having ‘a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live’ (Department of Health, 2012, p.6). The NHS Confederation (e.g. 2012, 2014), NICE (e.g. 2014), and the King’s Fund (e.g. Goodwin et al., 2010) also recommend recovery practice, and assert that top priorities for mental health services include supporting self-management, educating people about their conditions and expanding the peer workforce (workers with expertise by personal experience of mental health challenges).

At the same time as the push for cultural change there are pressures on services to increase productivity, deliver efficiently and meet increasing demand whilst challenged by diminished resources (NHS Confederation, 2014). Introducing group-based alternatives to individual interventions in mental health services is one way in which this might be achieved. Interventions that connect service users with others with similar experiences can have additional advantages when they enable people to learn coping strategies, develop relationship skills, reduce isolation and gain hope (Corey et al., 2013).

Recovery colleges offer an educational, non-stigmatising approach to recovery from serious mental health challenges. We are a group comprising a student, a peer trainer and some of the professional staff involved with two recovery college pilots. Here we report on an evaluation of these pilots in terms of student outcomes, uptake of courses and resource use. Results suggest that recovery colleges can contribute powerfully and efficiently to recovery and well-being.

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‘I would highly recommend the Recovery College to others, especially anyone on a personal journey towards more positive health and well-being’. (Recovery College Student)
Recovery colleges are a relatively new approach to serving the needs of people with serious mental health challenges within an educational rather than therapeutic model. Service users become students and undertake courses designed to empower people to manage their own recovery. All aspects of the college and its courses are co-designed and co-produced by experts by personal experience of mental health challenges alongside experts by professional training. They are strengths-based and person-centred; inclusive for people with mental health challenges, their relatives/carers and staff; mental health recovery oriented; and progressive, helping people reach their own goals (Perkins et al., 2012; McGregor et al., 2014).

Students choose what courses they want to go on from a prospectus. Personal tutors offer information, advice and guidance, develop individual learning plans based on students’ hopes and aspirations, and identify learning support needs. Following course attendance, students graduate with certificates of success. Courses aim to support students to develop their own resilience, follow their aspirations and become experts in their own care.

Recovery colleges have been well received, with positive feedback about the process of co-production of the college itself, as well as about courses (Meddings et al., 2014). After attending, students feel more hopeful about the future, more able to achieve their goals, have their own recovery plans, more friendships and work opportunities, and use mental health services less (Rinaldi & Wybourn, 2011). Recovery college ‘provides a catalyst for change and even transformation through an educational orientation... It enables them [students] to re-define their personal experience of mental health issues, (re)create an identity beyond illness and explore new social networks and supports’ (McGregor et al., 2014, p.13) Students value learning from each other, the co-production approach and lived experience, learning new skills and knowledge, and choice and progression to personal goals (Meddings et al., in preparation). These findings are based on initial audits – there is a need for robust outcome evaluation and research.

This paper describes an evaluation of Sussex Recovery College, highlighting student outcomes and potential efficiencies of the recovery college model.

**Background – Sussex Recovery College**

Sussex is a large county on the south east coast, with a population of 1.6 million. Two pilot recovery colleges were created in 2013 in Brighton and Hastings by a partnership of Brighton and Hove Mind, Activ8 (Hastings and Rother Mind) and Sussex Partnership NHS Foundation Trust. Both pilots were based in relatively deprived urban areas with affluent surrounding areas. The development of the college is discussed in our case study of the co-production of Hastings campus (Meddings et. al., 2014).

The majority of students were people with mental health challenges: 60 per cent were using secondary mental health services and 18 per cent primary care; 8 per cent were relatives or carers (11 per cent, including carers with mental health challenges) and 16 per cent were staff. The majority identified as female (66 per cent); white British (86 per cent); and heterosexual (85 per cent); there was a spread of ages from early 20s to late 80s, with 76 per cent aged 25–54. Of those using mental health services, PbR clusters showed 62 per cent had anxiety or depression, 37 per cent psychosis and 1 per cent dementia. The average HoNOS score was 11.9.

**Method**

We evaluated the two recovery college pilots using self-reported student outcomes: personal recovery goal attainment, learning outcome attainment, well-being and quality of life. In one site we also measured uptake and resource use. The methodology, including overall aims and choice of measures, was co-produced by a team of potential students, peer trainers and mental health professionals.

**Procedure**

A pragmatic sample of students who had been offered places on courses were asked to take part in the evaluation (those who registered on the days the interviewer was present on site). Students were approached by telephone when...
they were invited for their Individual Learning Planning meeting. Students were supported to complete outcome measures before attending their first course (pre) and after the end of their final course (post) at the end of term.

Participants
Seventy percent of those asked agreed to take part in the pre/post evaluation. Thirty-five students completed both pre and post interviews. The participants were representative of students as a whole in terms of age, gender, sexual orientation, ethnicity, religion and disability. We interviewed mainly students with mental health challenges, who were prioritised for ILPs - staff and carers were underrepresented. More students from Hastings than Brighton took part in the evaluation.

Measures
Self-report measures were used, including bespoke measures designed for the pilot and standardised questionnaires:

Personal goals
Recovery is a unique and individual process. The team thought that the most important measure was whether or not students made progress towards their own personal goals. Students were asked to prioritise their three most important goals in life and rate them on a Likert scale (range 1–7).

Course learning outcomes
Trainers provided three main learning outcomes for the courses they co-produced. Students were asked to rate themselves in relation to each of these for each of the courses they attended (up to three) on a Likert scale (range 1–7).

Standardised questionnaires
The following questionnaires were used:

- Process of Recovery Questionnaire (Neil et al., 2009) – a measure of personal recovery, constructed with service users (including hope, control and opportunity) (0–88).
- Manchester Short Assessment of Quality of Life (MANSAA) (Priebe et al., 1999) – a measure of quality of life (1–7).
- CHOICE short form (adapted from Greenwood, 2010) – a service user-led measure assessing psychological recovery and mental health (0–11).
- Warwick and Edinburgh Mental Wellbeing Scale (short form) (SWEMWS) (Tennant et al., 2007) – a measure of general well-being and psychological distress (7–35).

Objective measures of socially valued goals
Students were asked about employment status, whether they were students outside the college, and how many friends they had who they could talk to about mental health and recovery.

Demographic information was collected through college registration forms.

Analysis
Descriptive statistics were computed. Statistical comparisons of measures before and after attending the college were made using two-tailed nonparametric tests. Wilcoxon signed-rank test was used to analyse all measures except the categorical socially valued goals, where McNemar’s chi-square test was used. Quotes are taken from course feedback forms to illustrate the findings in students’ own words.

Results
Student outcomes
There was a high level of student satisfaction, with 97 per cent reporting that they would recommend the course they had completed. Students commented on feedback forms:

‘I feel more able to control my own recovery.’

‘It was helpful to learn techniques that help me manage my anxiety.’

‘I also made so many friends. I feel included, not alone.’

‘Improved self-esteem and confidence.’

‘The course was useful, informative and easy to follow. It taught me CBT that I could understand. I was able to increase my management...’
skills. It put me in the driving seat. It improved my sleep, and my feelings around sleep. I’ve been able to do more in the day.’

Students made significant progress whilst attending courses at the recovery college. The three most commonly cited personal recovery goals were ‘gain confidence’, ‘increase knowledge and/or skills’ and ‘meet other people’. There were large pre-post effects observed on all student self-reported outcomes (see Table 1).

We worked out individual reliable change for the CHOICE. Some 63 per cent of students showed individual reliable improvement (1.45+). All but one of the others showed some improvement – no one changed reliably for the worse.

In terms of socially valued goals, no significant differences were found for paid employment (\( p = 0.63 \)), voluntary employment (\( p = 1.00 \)) or becoming a student (\( p = 1.00 \)). There was a significant increase in the number of friends students felt like they could talk to about mental health and recovery (\( p < .05 \), \( Z = -2.432 \), effect size = 0.45).

### Uptake and resource use

The recovery college has been popular. During the pilots over 300 students registered. The most popular courses were:

- Happiness;
- Mindfulness;
- Using the Arts to Aid Recovery;
- Coping with Depression/Anxiety;
- Coping Strategies and Problem Solving;
- Improving your Sleep (CBT); and
- Understanding a Diagnosis (and Formulation) of Psychosis/Mood Disorders.

We worked out resource use for one pilot (Hastings). There were 29 courses, with an average number of 11 enrolled students; 319 course places were offered and 214 attended. Attendance rates of 67 per cent were within typical levels for mainstream adult education. In total, 1069 taught sessions were attended.

Including individual learning plans, planning and supervision, the total staff time per course (for two tutors) was 56 hours and face-to-face student hours was 85: a ratio of 5:9 (i.e. every five hours of staff time produced nine hours of student contact). Enrolment and graduation increased both staff time and student contact.

### Discussion

High levels of student satisfaction were achieved and large gains were apparent in student self-report measures: attaining personal goals, achieving course learning outcomes, personal recovery (PQR), psychological recovery and mental health (CHOICE), well-being (SWEMWBS) and quality of life (MANS). The evaluation indicates that uptake and resource use compares favourably with indi-

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Table 1: Mean, standard deviation (SD), Z score, \( p \) score and effect size for each measure and \( N \)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Mean (SD)</th>
<th>( Z )</th>
<th>( p )</th>
<th>Effect size</th>
<th>( N )</th>
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<td>-5.16</td>
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<td>Course learning outcomes</td>
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<td>-4.06</td>
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<td>0.78</td>
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Individual interventions and could offer an efficient alternative form of provision to some aspects of existing mental health services.

Audits of other recovery colleges show increased progression to work and mainstream college (Rinaldi & Wybourn, 2011). Similar impact was not demonstrated during the pilot, although this would perhaps be more meaningful to measure at a later follow-up.

The qualitative feedback from students suggests a powerful impact of the college and potential for it to transform traditional dynamics between mental health service users and providers. The personal account of one of us (HL), a student who took part in the evaluation, illustrates this:

*The prospectus outlines opportunities for learning and puts you in control. You choose what might help you. That is empowering. At an individual learning planning meeting you are welcomed, and supported by a peer to focus on personal goals, and knowledge and skills to be gained. Filling in a series of questionnaires for the RC Evaluation could have been a daunting task, but our staff were so positive that it became fun and relevant. I achieved my goals of improving social skills and confidence. The course learning outcomes measures helped me to chart my progress. I was surprised and pleased to see how much I had learned. Peer experience ensures a deeply empathic feel to learning, helping professional research theory to come alive. Experience from fellow students creates an extra supportive dimension and opportunity for friendships to develop. The graduation is a special occasion which marks group and personal achievement and success. Now I am proud to be a student representative, I am applying to train and work in peer support and have been discharged from mental health services.*

Routine outcome measurement is recommended. A randomised controlled trial of the recovery college is needed to assess efficacy. Follow-up studies could determine whether changes are maintained over time, the longer-term impact on service use, and progression to employment and mainstream education. Systematic qualitative studies could explore core characteristics of the recovery college and whether key effective components, for example, are the employment of peers, co-production, students taking control of their recovery, or the courses themselves. Recovery college students choose what they think will work for them – this raises a research question about whether service users are as good as mental health professionals at assessing or deciding what particular treatments or interventions might help them most.

Recovery college offers one solution to providing interventions for mental health challenges efficiently, enabling services to reach more people than could be helped by individual interventions within the same resources. Recovery educational approaches need to be integrated with other aspects of mental health services so that progress made by students can be optimised. Mental health teams can support students whilst they are at college, then with further progression after graduation – including thinking with them about employment, further education and discharge from services.

Recovery colleges combine the expertise of mental health professionals and peers with lived expertise in an educational context where students take control of their own recovery. They are a promising new approach to mental health with much scope for further development.

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**Acknowledgements**

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References
FOR A QUARTER of a century I have occupied that strange ‘no (wo)man’s land’ between ‘them’ and ‘us’. I have worked in mental health services and have lived with a long-term mental health condition that has taken me to the receiving end of both in-patient and outpatient services. And throughout this time I have written, spoken, campaigned, sat on government committees, and generally tried to change the world (see Perkins, 1999; Davies et al., 2011). My motivation for these various endeavours? A passionate commitment to improving the lives and life chances of those of us with mental health conditions. My dream? A world in which people with mental health challenges can participate as equal citizens in all facets of community life. A world in which the experience of mental health challenges, and the expertise and insights it brings, is positively valued.

My first ‘psychiatric career’ took me from Assistant Psychologist, via training and progression through Clinical Psychology to Clinical Director and Director of Quality Assurance & User Experience. Since my retirement from the NHS I have worked as a freelance consultant and trainer across the UK and beyond, and have been a senior consultant with the national ‘Implementing Recovery through Organisational Change’ (ImROC) programme.

In this career, I rapidly learned who the real experts are. I saw the casualties of our system: people driven to the margins of our society who had given up on themselves and their possibilities as a consequence of segregation within services and the pessimistic prognostications of those who were supposed to help them (Perkins, 2001). But among those whom I had the privilege to serve, I also found the most amazing wealth of courage, creativity and ingenuity in surviving, and thriving, in the face of what seemed to me like insurmountable odds.

Like any mental health professional, I had taken it upon myself (in the nicest, most sensitive and respectful way, of course) to tell people what was wrong with them, and how this could be put right, on the basis of the models my profession had invented. But the limitations (and arrogance) of the theories and therapies I had been taught rapidly became apparent to me. I began to question the whole clinical paradigm in which mental health discourse has been couched.

Most people I met wanted a life, not a psychologist, and the extent to which the psychological therapy could assist in this ambition was limited. Of course some people value the treatment and therapy, but I became convinced of three things:

- a focus on the reduction and elimination of deficits and dysfunctions is a woefully inadequate framework for understanding the challenges people face;
- consigning mental health challenges to the province of ‘experts’ has a destructive impact on the lives of both people experiencing them and our communities; and
- the balance of power was all wrong.

My concerns were reinforced during my second ‘psychiatric career’ as ‘mental patient’. This was not a career of my choosing, but it is one that has been central to the making of me, and through which I have gained more understanding and expertise than my clinical training ever afforded. I felt completely at sea, without map or compass, amazed at how little my professional training helped me to navi-
gate life with mental health problems, and appalled to be on the receiving end of the advice of so many ‘experts’. At first, my sole aim was to ‘get better’… and as my problems receded, so I thought I could ‘put all that behind me’: a strange aberration that could be consigned to history. But it was not as easy as all that. The challenges I face did not disappear but returned from time to time. I have come to understand that they are part of me… a valued part from which I have learnt and grown. Now I almost feel sorry for people who have never experienced the extremes of human emotion and cognition.

But what I couldn’t accept was the way people started treating me differently. Back in 1990, I moved from ‘Rachel Perkins, successful psychologist’ to ‘Rachel Perkins, the mad psychologist’ and all people seemed to be interested in was how I could simultaneously be both a psychologist and a mental patient. I was also at great risk of losing the first of these because of the recommendations of the ‘Clothier Report’ (1994), which said that people should not be employed within the NHS within two years of having received treatment for a mental health problem.

It was not until I spent some time in the US in 1993, that I found a way of thinking about madness that made sense to me as both provider and recipient of mental health services. I met amazing people like Judi Chamberlin, Mary O’Hagan and Patricia Deegan… and was introduced to ideas about recovery and a rights-based, social model. The ideas they espoused were not born of learned professionals, but emerged, within the civil rights movement, from the lived experience of people who had themselves faced the challenge of living with, and growing beyond, the identity of ‘mental patient’. Their ideas challenged traditional clinical ways of knowing. These were replaced with the expertise gained from the individual and collective narratives of those who have experienced emotional crises, grown stronger because of them, and rebuilt meaningful, valued and contributing lives. It is these narratives of lived experience, not professional theories about the aetiology of distress, on which ideas about recovery are based.

Professional expertise moves from centre stage to the margins and power relations must be changed. One of the greatest powers that professionals have taken upon themselves is the right to define reality, and those who do not share these expert constructions are deemed ‘lacking in insight’, thus legitimising compulsory detention and treatment – for their own good, of course!

The recovery philosophy’s cornerstones of self-determination, connection to our communities, social justice and a broad choice of services are a direct challenge to the use of compulsory interventions, particularly if they are not applied on an equal basis with other citizens. (O’Hagan, 2014, p.245)

Fundamentally, ideas about recovery are about ‘recovering a life’ rather than ‘recovering from deficits, dysfunctions and problems’. The journey within and beyond emotional crisis: the process of making sense of what has happened, recognising your own resources and resourcefulness, and having fertile ground in which you can grow within and beyond what has happened to you. Hope and images of possibility are critical, as are taking back control and having the opportunity to do the things you value and participate in as an equal citizen (Repper & Perkins, 2003, 2012; Perkins, 2012).

Although recovery is a personal journey, it is not a journey travelled alone. It takes place in a social and political context. This is one of widespread negative stereotypes, prejudice and discrimination that denies rights and erodes opportunities. Within a clinical paradigm, attempts to promote inclusion typically revolve around ‘changing people so they fit it’ via treatment and therapy of various hues. The shortcomings of such an approach are evident. Over the decade of the Mental...
Health National Service Framework (Department of Health, 1999) access to psychological therapy increased markedly (via IAPT), as did access to mental health services and treatments more generally (like Early Intervention and Assertive Outreach Services). Yet social isolation increased and access to employment, education, and stable and appropriate housing has decreased (Department of Health, 2013; Office for Disability Issues, 2013). Some 88 per cent report experiencing negative discrimination in at least one area of their lives and 72 per cent felt they had to conceal their mental health problems for fear of the prejudice and discrimination that would result if they were open about them (Corker et al., 2013). No amount of treatment and therapy can break down the prejudice and discrimination that deny inclusion and citizenship. A different approach is required.

The broader disability world has long recognised the limitations of a clinical approach, opting instead for a ‘social model’:

It is attitudes, actions, assumptions – social, cultural and physical structures which disable by erecting barriers and imposing restrictions and limiting options… The social model of disability is about nothing more complicated than a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment… (Oliver, 2004, p.23)

Patricia Deegan (1992) recognised that a similar social model was equally applicable to people with mental health conditions within a recovery framework:

For most of us, mental health problems are a given… the real problems exist in the form of barriers in the environment that prevent us from living, working and learning in environments of our choice. [The task is] to confront, challenge and change those barriers and to make environments accessible… environments are not just physical places but also social and interpersonal environments… those of us with psychiatric disabilities face many environmental barriers that impede and thwart our efforts to live independently and gain control over our lives. (Deegan, 1992, p.11)

The real challenge is to create communities that can accommodate all of us:

Inclusion and citizenship are not about ‘becoming normal’ but creating inclusive communities that can accommodate all of us. Not about ‘becoming independent’ but having the right to support and adjustments (in line with our choices and aspirations) to ensure full and equal participation and citizenship.’ (Perkins and Amering in Slade et al., 2014, p.14)

But inclusive communities are unlikely to be achieved solely by ‘raising awareness’ and asking people to ‘be nice’ and ‘include us’. The broader disability movement has long recognised that there must be the backup of rights enshrined in law. Judi Chamberlin (1993, 1995) argued that the rights of psychiatric survivors were a core part of the broader disability rights movement. Thanks to the endeavours of consumer/survivor activists and their allies across the world, both national disability equality legislation and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, United Nations, 2006) explicitly include people with mental health conditions. UNCRPD Article 19 describes the right to ‘live independently and be included in the community’, but this right is not contingent on ‘getting better’ or living without support: it includes the right to the assistance necessary to support inclusion and prevent isolation or segregation from the community.

So what of professional expertise? Some people find therapy and other treatments helpful in alleviating distress but the balance of power must be changed (Perkins, 2012; Repper & Perkins, 2003, 2012). Professionals need to move from being ‘on top’ (defining people’s reality, possibilities and the therapy/support they need) to being ‘on tap’: readily available for those who may wish to use them: ‘Carriers of technologies that we may want to use at times, just like architects, plumbers and hairdressers.’ (O’Hagan, 2007, p5).

As my perspective changed I became increasingly less satisfied with my role as clinical psychologist... if I wanted to improve the
opportunities of those whom I served, I had to change the world! Within the mental health world I became a clinical director, then a director. I started setting up new initiatives, like employing people with lived experience of mental health problems in mental health services, supporting people to gain and sustain their own homes and jobs, setting up the UK’s first recovery college, leading on the development and delivery of a strategy to promote more recovery-focused practice within the organisation for whom I worked. My involvement in campaigning and attempts to change policy and practice on a national stage increased. I also began to become engaged in ensuring that mental health conditions form a core part of the broader disability rights agenda, initially via, for example, involvement with the work of the Disability Rights Commission and Equality and Human Rights Commission, membership of the Disability Employment Advisory Committee and chairing the cross-government strategic advisory group on disability issues (Equality, 2025).

So looking back over the 20 years that have passed since my introduction to ideas about recovery, what progress has been made? Well, on the rights agenda, mental health conditions are explicitly included in the UK Disability Strategy and associated policy initiatives. The Mental Health (Discrimination) Act (2013) has removed the restrictions on people with mental health challenges serving as jurors, company directors or members of parliament. But I remain deeply concerned and question whether mental health services as we know them can achieve the changes necessary to genuinely promote the recovery and rights of those whom they serve.

The ideas about recovery I encountered in the US in 1993 were firmly rooted in the mental health user/survivor movement and a rights-based framework. Although this has also, to some extent, been the case in the UK, in large part, ideas about recovery in England have been driven by professionals and policymakers (see, for example, DoH, 2001, 2009; HM Government, 2011; NIMHE, 2005). The word ‘recovery’ permeates national and local mental health strategies. We have seen the development of recovery colleges, peer support workers, recovery training and recovery indicators. However, it seems to me that, in the hands of well-meaning (but powerful) professionals, concepts of recovery have too often become distorted into a clinical model of service provision. Recovery becomes ‘getting better’ and discharge from services – no mention of rebuilding lives, just taking away the supports. Increasingly, I hear talk of ‘recovery models’ (yet another professional model alongside ‘medical models’, ‘psychological models’, ‘systemic models’…), ‘recovery interventions’ and ‘recovery teams’. recovery seems to be becoming something that professionals and services do to people rather than an individual journey of discovery (Perkins & Slade, 2012).

The overarching belief is that bigger, faster services that can intervene early are ‘a good thing’… but in achieving this, connections with communities can easily be lost (O’Hagan, 2007, 2014). Large, highly professionalised services can perpetuate exclusion in a kind of vicious circle. People in mental distress are led to believe that experts hold the key to their problems. Their nearest and dearest believe that the person they care about is unsafe in their untrained hands – better leave it to the experts who know what they are doing. And we all become less and less used to finding our own solutions and embracing distress as part of everyday life – the very opposite of creating communities that can accommodate all of us.

But most importantly, I really don’t see the crucial change in the balance of power that is required to foster self-determination. The idea that ‘professionals know best’ remains endemic: professionals both prescribe when people need help (‘assess suitability for therapy’, ‘gate-keeping’ services) and what sort of help they need in the form of treatment, therapy and support. If the force of verbal persu-
sion and NICE guidelines fails then the force of law is used. At the same time as ideas of recovery have become popular, rates of compulsory detention and treatment have risen alarmingly. In 2012/13, both the number of detentions in hospital and the number of people on community treatment orders (CTOs) rose to the highest ever recorded (Care Quality Commission, 2014):

- 2012/13 total detentions = 50,408
  (up from 38695 in 1997/8; 44,093 in 2007/8; and 48631 in 2011/12).
- 2012/13 total on CTO = 4.647
  (up from 2,134 in 2008/9).

So much for the recovery cornerstone of ‘self-determination’! At the very least, surely we should be demanding plans for reversing this trend as is the case in Norway (Norwegian Department of Health, 2006). In relation to CTOs, serious questions must be asked in relation to the continuation of these, especially given the findings of the UK ‘OCTET’ trial which found ‘no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients’ personal liberty’ (Burns et al., 2013, p.1).

Quite apart from impeding recovery (O’Hagan, 2014; Slade et al., 2014), the Annual Report of the United Nations High Commissioner for Human Rights states that UK mental health legislation contravenes Article 3 (‘respect for inherent human dignity and individual autonomy including freedom to make one’s own choices’), Article 12 (people must ‘enjoy legal capacity on an equal basis with others in all aspects of life’) and Article 14 (‘the existence of disability shall in no case justify deprivation of liberty’) of the UNCRPD (see Szmukler, 2010). As the United Nations Committee on the Rights of Disabled Persons is shortly to commence an examination of how the UK is performing in relation to the UNCRPD perhaps this is a good time for action.

So to conclude, my journey has taught me that recovery happens – people can and do rebuild valued, satisfying and contributing lives – but that we need fertile ground in which to grow. Hope inspiring relationships and environments where we can explore our own reality (rather than have it defined for us by the experts) and take control over our lives and destinies.

As ideas about recovery have become powerful, so they are being ‘taken over’ and professionalised by powerful professions and services who may be fearful of relinquishing their power to define reality and prescribe what is good for people:

> The most challenging decisions ahead are not how to increase access to professional services but how to maximise life chances and enable people with mental health conditions to make the most of their lives. The real challenge is how to do things differently and use resources differently: recognise the limitations of traditional professional expertise, the value of the expertise of lived experience and rekindle the belief that citizens hold most of the solutions to human problems. (Perkins, 2010, p.36)

But:

> The biggest barrier to recovery is stigma and discrimination, whether it comes from ordinary people, community leaders, mental health workers, families or mad people themselves. (O’Hagan, 2014, p.229)

Prejudice, discrimination and exclusion cannot be reduced by consigning human distress to the realm of professional services. Ideas about recovery were born in the civil rights movement. The language of rights offers a more empowering and liberating framework than that of individual deficits, dysfunctions and needs. It is by replacing ideas about ‘needs’ with ideas about rights that we can move, in the words of Liz Sayce, from psychiatric patient to citizen (Sayce, 2000). Not just rights to treatment and support, but those positive rights: to live independently, participate on equal terms in all facets of life, and have control over our destiny and the support/treatment we receive.

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Sharing stories of recovery in Uganda
The Sharing Stories Venture

The Sharing Stories Venture was honoured to be invited to undertake a series of listening events in Uganda during February 2015 to explore the understanding of recovery in a Ugandan context. The subsequent events not only provided an insight into the views of both service providers and users on the concept and contributing factors in recovery but also valuable lessons on running knowledge exchange events within Uganda.

The Sharing Stories Venture are a group of people who access mental health services, mental health professionals, trainees and educators from Uganda and the UK who work together to develop ability and knowledge through a shared understanding of mental health. Sharing Stories were invited to run the Ugandan recovery listening events as part of the Tropical Health Education Trust funded Brain Gain 2 project (www.mhinnovation.net/organisations/butabika-east-london-link), a three year grant to develop training for peer support workers and mental health professionals across Uganda. As an established group with defining principles of equality and inclusivity, the task of collaboratively identifying them selves in recovery was an ideal fit for the Sharing Stories Venture and a group of six UK members (representing people who work in services and people who access them) travelled to Uganda to facilitate the events alongside their Ugandan colleagues. The lead for these events was one of the UK facilitators – christened the ‘wise old man’ by a Ugandan colleague – although this is a rotating role between UK and Ugandan members within Sharing Stories. The key task to be undertaken was to answer the following questions:
1. What is recovery?
2. What helps achieve and maintain recovery?
3. What hinders recovery?

The process of collaboration
Prior to UK members arriving in Kampala, extensive preparations had been made using conference calls. The planning of the four events which the group were to run was a truly collaborative process between both countries, but this is not always a simple process when members are over 4000 miles apart. While the use of technology such as Skype allowed the group real-time discussion, frequent connectivity issues owing to technology problems in both countries hampered many meetings. Although the time difference between the countries is relatively small, this still caused some problems when identifying suitable meeting times for members with a variety of roles, diverse responsibilities, and varying access to technology. Members also found it hard to form relationships with individuals whom they had not yet met, and poor quality audio often meant that identifying individuals could be more difficult. The group lead also found that it was often hard to draw conversations to a consensus due to difficulties in seeing or hearing the reaction of individuals to the many and various points made. While the decision-making processes surrounding the development of the events was time consuming, the choices made were so thoroughly explored that they were almost never revisited and the clear roles and responsibilities that were defined within the group meant that these issues did not impact seriously on successful planning.

Running the listening events
The events used a combination of group discussion sessions and one-to-one listening over four separate days. The questions which guided this process had previously been developed by two Sharing Stories members (one Ugandan, one British) and refined by the larger group; a process which enabled both
rapid development and wide participation. The four events targeted different participant groups in order to examine the potential for variations in response. Three events were held at the main mental health referral hospital in Uganda, which catered for people who use mental health services, carers and professionals from the capital, Kampala, and a dedicated event for people who use mental health services and professional representatives from the six regions identified by the Ministry of Health for Uganda. The fourth event was held in Jinja, a town in southeast Uganda, to enable an in depth consideration of a regional perspective on recovery.

It became clear that locating events within the mental health hospital had an emotional impact on some attendees. The event in Jinja was located in a hotel and this served to mitigate these issues, potentially resulting in a less emotive experience and reduced distress for participants as a result.

Facilitators made a conscious effort to flatten power structures by avoiding job titles, not providing individual introductions of facilitators at the start of the day, and running groups for people who use mental health services and professionals separately before coming together as a larger group to discuss emergent themes. This encouraged personal connections from the outset, as facilitators could meet attendees and work together as equals to explore their experiences. Meanwhile, the separation of people who use mental health services and professionals increased the freedom of both groups to voice their opinions with less restraint.

The option to participate in either a group or one-to-one session with a facilitator was given to all participants. Art materials were also provided for those who wished to explore alternative expressions of their experiences. An opportunity for attendees to use poetry and music was also provided, with several individuals using this to great effect.

The personal stories shared in the morning sessions were used to identify key themes, often numbering in the hundreds at a given event. These were summarised into meta-themes each day and presented to the attendees in the afternoon to ‘check we listened well’ and to give an opportunity to add, remove or alter the themes. Each day also included feedback from facilitators who use mental health services in the UK and Uganda, who provided a personal summary of the day.

**Interpreting stories for recovery themes**

It was apparent that the richness of information and holistic nature of the themes revealed in the stories of participants was of great importance. At each event the meta-themes were pulled open again by participants so they could explore and share the detail of the themes inside. When the facilitators looked to work with participants to explore ordering the themes, many found this very difficult, indicating the importance of considering the breadth of experience in a holistic manner. When participants were able to identify a key theme their selections were extremely varied, highlighting the individual nature of the experiences of recovery and the importance of valuing personal narrative.

In order to run each listening event effectively within its time constraints, identifying meta-themes was done fairly rapidly each day. However, the summation of all meta-themes that was undertaken following the events involved much more reflection on their wider context, how they overlapped and the complexity of those which interlocked. This was only possible with the input of all Sharing Stories members due to the variety of contexts in which themes were raised by participants and the varying interpretations of the facilitators. Ensuring that the themes remained grounded in the experiences and social environment of the participants who provided them remained the key objective throughout. Although the final themes identified were filtered through the belief systems of all Sharing Stories members, by being mindful of this fact an honest attempt was been made to capture the essence of the stories using the language of the story teller.
There are many similarities in the themes emerging from these events and those identified as common to concepts of recovery in the UK and other western nations, such as hope, empowerment and having meaning in life (Leamy et al., 2011). The most striking difference was the emphasis on finances in Uganda. While the UK benefits system and NHS provides those experiencing mental health difficulties with minimum levels of support, the experience of Ugandans is one of social stigma and personal difficulties exacerbated by significant financial distress. However, even within this common theme, participants saw many individual priorities for how financial support was best used. Suggested priorities included providing better medication, accessing education, developing income generation schemes, or simply ensuring that basic needs were met, such as having a safe place to live and appropriate food being available. As with all other emerging themes, using the individual’s needs and priorities were at the heart of defining that person’s recovery.

Using the knowledge

The listening events have not identified a solution to implement recovery in mental health – they have obtained an initial understanding of people’s experiences, allowing others to build upon this learning, both in Uganda and the UK. In order to share the learning which occurred at the events with all participants, Sharing Stories are creating a booklet of findings for distribution to everyone who attended. This will reflect the rich and varied nature of the experiences that were shared, and will hopefully support everyone involved to build on their own learning at the events. The Brain Gain 2 project will use this learning to inform the development of their peer support worker training, which will begin in 2015. As part of that project, four people will come to the UK at the end of the project to share their learning. Sharing Stories are focused on providing ongoing exchange opportunities, both before and after this date. The group were encouraged to run these events as both implementers and innovators, exploring and adapting the ways in which the events ran, dependant on the ongoing learning and defining the manner in which the learning would be expressed, the Brain Gain 2 project team based on the priorities of participants. They operated with an open mind, having consciously put aside everything they knew about recovery outside Uganda and hearing much more as a consequence. Sharing Stories’ desire is to organise for Ugandan members to join in running similar listening events on recovery in the UK with the same premise of equality, inclusivity and listening well without preconceptions.

The Sharing Stories Venture

The Sharing Stories Team is made up of staff and service users from Uganda and the UK: Will Curvis, Jenny Davies, Keith Holt, Benon Kabale, Rosco Kasujja, Lynda Esther Nakalawa, Edward Nkurunungi, JJ Paul Nyeko, Samuel Ouma, Rob Parker, Bethan Roberts & Helen Walls

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Reference

WHAT A GIFT to be invited to write a free flowing piece about recovery through poetry and art. If I could offer one thing to my younger selves, it would be to have a glimpse of the meaningful patterns that appear as we look back upon what we express, manifest and create in our lives; how our earliest images can already have everything in them that we later articulate into a story, a coherent narrative of our experience from which we extrapolate our unfolding self.

In 1974, age three, I was sexually abused by a man who befriended our family and offered to babysit. I know this registered in my body, in my relationship with myself, a sense of pervasive shame and ‘badness’. I know I expressed this in distress, tantrums at home, withdrawal, crying, vulnerability at nursery and school. I don’t know whether I knew then what was happening to me, whether I would have been able to give any kind of verbal account, or to tell about it. I know that it must have been stopping by around the time I was seven and receiving family therapy. In 2012, having finally pieced together what I did know then with a coherent narrative now and reported this to the police, I was able to gain access to the images I drew in therapy at seven. We had lived in the upper floors of two different high rise flats during the time of the abuse. I had recurrent nightmares of a man in a park killing all my family and I wet the bed during those years. Every time I look at these drawings, I see more; I feel more astonished, more compassion and love for that little girl and her clarity about what had been happening through her drawings.
This is my story, in its wholeness, but I will fill in the gaps now between these early formative experiences and the story I articulated forty years later. How I came to know what I had always known.

Firstly though, my motivation in sharing my story publically is that we can all learn from this courageous little girl, and so many other children, to listen better, to bear knowing what we push from our minds; that those we love, trust, depend on, know well, can and do sometimes betray us and hurt our children. We need to find ways to engage with the ordinariness of this harsh reality, so that we can see and intervene with what is happening. Tragically, as the police identified the person who had hurt me and I felt a deep sense of resolution, abuse was being repeated elsewhere in my family system, again unseen, unknown. I had not seen the signs, or at least had not registered and known in the way that I needed to in order to understand. Just like adults had tried to explain (away) the problems with me, so I had made the same mistakes as an adult. We need to stop tying ourselves up with guilt, regret, horror and despair, and start acting to be a small part of the solution so that we are ready to hear what is happening when we are told.

It is hard to say when our healing through creative expression starts. Mine was certainly well established by seven in my drawings and I have witnessed extraordinary creative expression in children under two. I liked writing stories and one stands out about something foreboding in an attic. I used to read others’ poetry and sing songs (including comedy ones) with such sincerity – I have heard the recordings – as though I was trying to drink up all their goodness, their rightness into me; wash away the bad. It was in my early twenties that images began to arise demandingly. Spirals first, powerful, vibrant spirals of outward moving energy – predictive. A few years later, body memories, terror, panic attacks in the middle of the night, being crushed, unable to breath, numbing, profound debilitating tiredness, clenching jaw, pain in my vagina, rage that I felt could pull down trees, searching for answers, finding none. I was beginning to receive at the core of me, to let in love, to be not alone in these frightened, fragmented places. Poems, five poems, arrived one day in a rush, whole before me; five organisations of self, adaptations, as plain as day – me. Within each poem the resolution, the final release from the fixed configuration of self – still unfolding, manifesting twenty years later.

More energy, more drawings and now dancing the five rhythms; sound like the images flowing through me. I would feel sound pushing from within my being, I would open and allow it to pass through me...
in awe and fear. It would contort my body, releasing the compressed energy, the tightened muscles, so much aching and contracting in those days.

I began to experience my physicality differently, less clumsy, more fluid – I learnt to do breast stroke, to float, cycled more and started yoga. I still contracted, struggled with depression, felt easily shamed and anxious in social situations, and often overwhelmed and needing to retreat. I kept on trusting, letting in loving, skilled support of those by my side.

Ten years later the story began to emerge, to be knowable. The man who befriended my young parents in a play park, had told stories in common with them, and arrived regularly to offer to babysit. A name for him even – it began to seem real. Perhaps my experience was real, and perhaps these feelings that I had about me were not mine to hold. More memories, visual, but vague; more body sensations; more art work, now in further therapy training. Sandtray work, especially wet sand, reaching to the depths of my experience. Then the poems proper, very slowly at first, one every six months, then more and more, until one day not long ago, I realised this is who I am, how I have become who I am, and this is what I do.

What is extraordinary is how the images at seven, the images at 23, and 35, and the poems at 25 and 40, the sound and the dance, all echo one another completely, the wholeness is within them all. Not only wholeness of my experiencing then, but also my potential held within. I feel awe at the process and

I hope that this story will give you hope in your work and lives and that along with me you will feel moved to listen well to what is there for us to see.

Author
Emily Skye MA, Open University; emilyannskye@gmail.com; Twitter: @eskyepoet

References

Emily trained as a Gestalt and Integrative Child Psychotherapist. Following twenty years practice in health and social care, she has now turned her attention to writing, teaching and research in the field of mental health. She works for the Open University.

Fault
The night I ended the world
I died and woke up peaceful.

Purposefully
mightily
shifted the plate
then I knew.

The fault zone first
almost silent
whose fault
just fault.

After the still
inevitable, compelled
the land gave way.

Chasms, tremendous swathes
falling, folding in

Unfathomable sound
feel the falling beneath
foundations
all gone

falling, folded into earth
subsumed, embraced, consumed

I died and woke up peaceful
the night I ended the world.
Are we delivering recovery–based mental health care? An example of ‘co–produced’ service evaluation

Katherine Newman Taylor, Lesley Herbert, Chris Woodfine & Geoff Shepherd

This paper describes a co–produced pilot evaluation of secondary care services. The study was designed and run jointly by people with expertise through experience, and expertise through training. The results support the feasibility of co–production in such governance procedures in the NHS, which we suggest should now be expected as routine good practice.

Improving the quality of mental health services and the resulting experience for service users are national priorities (Department of Health, 2010, 2014; CSIP, RCPsych & SCIE, 2007; Centre for Mental Health, 2008, 2010). We need to close the iniquitous gap between physical and mental healthcare (see Department of Health, 2014). Following the Francis Report (2013), the Department of Health (2013a) endorsed a number of ethical, behavioural and regulatory changes required to effect culture change in the NHS. These are intended to cultivate more humane services and are consistent with a ‘recovery approach’ in which better quality relationships are paramount in effective healthcare.

Recovery

The recovery literature demands that we raise our expectations for people with serious mental health problems, and take seriously the lived experience and inherent agency of service users in all aspects of healthcare. These principles are now widely accepted in mental health discourse and policy (New Horizons: A shared vision for mental health, 2010; No Decision About Me Without Me, 2010; No Health Without Mental Health, 2011). Put simply, it is expected that more people with mental health problems will be supported to lead meaningful and satisfying lives irrespective of symptom status, achieving ‘personal recovery’ as opposed to ‘symptomatic recovery.’ The recovery approach thus provides a clear direction for modernising and improving mental health services (Repper & Perkins, 2003).

Measuring recovery outcomes

The Royal College of Psychiatrists (2013) identifies the need to ‘value the importance of outcomes and accurate data’ as one of five key principles underpinning plans to improve quality of services. If we are prioritising recovery outcomes in mental health care, this is what we should be measuring. In line with the move towards payment by results (Department of Health, 2013b), reliable and valid measures of personal recovery and the quality of ‘patient experience’ therefore constitute key healthcare outcomes.

Method

The study was discussed with our Trust Research and Development department, and it was agreed that formal ethics approval was not required for service evaluation.

Participants

Fifty-eight service users from sites across an NHS Trust in the South of England were recruited to the pilot evaluation. The sites included community mental health teams, an early intervention in psychosis team, and in–patient wards. The teams were selected from both working age and older adult services, and from across the geographical area.
Are we delivering recovery-based mental health care?

Measure
INSPiRE (Williams et al., 2014) is a measure designed to assess service users’ experiences of support received from mental health workers, in line with their recovery. The authors report acceptable internal consistency (Chronbach’s $\alpha = 0.82–0.89$) and test-retest reliability over two weeks (0.75) (Williams, personal communication). The questionnaire was developed for the REFOCUS study, a centrally funded research programme established to improve the recovery orientation of adult mental health services in England.

The 29-item INSPiRE is rated by the service user and yields two sub-scales: ‘Support’ and ‘Relationships’. The ‘Support’ sub-scale assesses the types of support considered important by the person, and the degree to which these are supported by the person’s mental health worker. The ‘Relationships’ sub-scale assesses the extent to which the relationship between service user and mental health worker is recovery focused. Ratings are made on a five-point scale from ‘1’ (not at all/strongly disagree) to ‘4’ (very much/strongly agree). The measure takes approximately 10–15 minutes to complete.

Minor amendments to the introductory wording were negotiated with the originators of INSPiRE, and an adapted version agreed.

Procedure
Pilot sites were identified, to include in-patient and community adult and older adult services from across the geographical area. A brief presentation was developed to engage staff in the evaluation. An independent local service user group was commissioned to assist people to complete the INSPiRE. Clinicians informed potential participants of the evaluation and invited them to take part. Where agreed, the independent interviewers contacted service users to arrange a time to meet. The interviewers were able to confirm the confidentiality of participants’ responses and explain any unfamiliar terms in the questionnaire. Service users were given information about the evaluation and asked to sign a consent form. Home- or clinic-based meetings were offered depending on the service user’s preference, and people were given the option of completing the questionnaire independently or as a structured interview.

Aims
The evaluation was designed to determine: (i) the feasibility of co-production in organising governance procedures; (ii) the feasibility of gathering service user reported measures across in-patient and community settings; and (iii) initial hypotheses about the quality of local services.

Results
Demographic information
Fifty-eight people took part. Table 1 gives numbers of people from each part of the service.

The majority of people involved in the pilot were linked to a community mental health team, and a quarter of the group were from in-patient units. Ages ranged from 24 to 77 years (mean = 47.6; SD = 16.2). The group was fairly evenly split between men ($N = 28$; 54 per cent) and women ($N = 23$; 46 per cent). Twelve people declined to give age and/or gender information. Participants had had a wide range of

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<th>Service group</th>
<th>Setting</th>
<th>Number of participants</th>
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<tbody>
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<td>Working age adults</td>
<td>Community mental health team</td>
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<tr>
<td>Working age adults</td>
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<td>9</td>
</tr>
<tr>
<td>Early intervention in psychosis</td>
<td>Community mental health team</td>
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<td>Older persons</td>
<td>Community mental health team</td>
<td>8</td>
</tr>
<tr>
<td>Older persons</td>
<td>In-patient</td>
<td>5</td>
</tr>
<tr>
<td>Total (one person declined to give this information)</td>
<td></td>
<td>57</td>
</tr>
</tbody>
</table>

Table 1: Pilot service groups and settings
number of ‘years’ contact with their current teams. Over a third had between one and five years’ contact (38 per cent) and over a quarter had over ten years’ contact (28 per cent). Five people declined to give this information.

**Qualitative feedback**
Feedback from the service user interviewers indicated that people valued being asked their opinions in some detail, that specific relationships were indicative of their experience of healthcare provision, and that the interview-based format facilitated the collection of accurate data.

In the opinion of the interviewers, participants valued the confirmation of confidentiality, which was stated clearly as part of the procedure and implicit in the fact that service-user peers were completing the interviews. All but two participants opted to complete the questionnaire as a structured interview. The interviewers noted that in the main people took care to give considered responses to questions. On a few occasions, participants requested clarification of the meaning of some words. Generally, however, items were understood and considered relevant, indicating good face validity.

**Quantitative data**
Participants gave a mean rating for Support of 2.8 (SD = 0.9; range = 4.0; median = 3.0), indicating that on average their key workers supported them in aspects of care important to their recovery ‘quite a lot’. Participants gave a mean rating for Relationship of 3.3 (SD = 0.7; range = 3.6; median = 3.5), indicating that on average they ‘agreed/strongly agreed’ that clinicians developed effective, recovery-based relationships with them.

**Summary and conclusion**
The cross-government outcomes strategy *No Health Without Mental Health* (2011) expects that ‘More people with mental health problems will recover… – [that is, achieve] greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live.’ (p.6)

Most mental health services now state a commitment to the principles of recovery and the need to place service user experience and involvement at the heart of healthcare provision. With Payment by Results, we will soon be expected to report routinely on ‘patient-rated outcome measures’ (PROMs) and ‘patient-rated experience measures’ (PREMs) as well as ‘clinician-rated outcome measures’ (CROMs) (Department of Health, 2013b). Reliable methods of assessing recovery-based outcomes, including direct reports of people’s experience of healthcare provision, are therefore key indicators of service quality.

It has been our experience over the course of this pilot that it is entirely feasible to co-produce service evaluation. The lived experience and professional role of the second author informed decisions about both the choice of measure and how to run the evaluation. A key decision was to commission an independent service user group to gather the information from participants in order to increase the likelihood that they would be willing and able to give honest feedback about local mental health care. The quality of the data supports this – almost all questionnaire items were endorsed, and response patterns showed reasonable variation within and between participants. In addition, comments made to the service user interviewers suggest that participants took care to understand the questions and give considered answers (as noted above). A deliberately flexible approach was taken to enable participants to engage in the study at a time and location convenient to them, and to complete the questionnaire independently or as structured interview. Working with the service user interviewers to co-produce data did involve a modest investment of time and money. We believe this to have been important in ensuring the quality of the information gathered.

Secondly, the INSPIRE instrument was completed by participants in both community and in-patient settings, and across age groups. Although just a pilot with a limited number of participants, a quarter of people completed the measure while in hospital, and a quarter from older adult services. The interviewers did not report any differences in people’s ability to complete the measure by setting or age.
Finally, in generating hypotheses about local services, the initial data indicate that while on average service users believed themselves to be supported in their recovery and that relationships with staff were effective, there was considerable variability in people’s experiences. The range of outcomes suggests that some of our services were likely to be performing highly and others were struggling to work effectively with people and towards their recovery. This allows us to start generating hypotheses about what contributes to local systems of effective practice as well as areas struggling to provide recovery-focused care. These hypotheses build on the literature that suggests it is the nature of day-to-day working relationships that most strongly predicts recovery outcomes, particularly in terms of the experience of services (Repper & Perkins, 2003; Centre for Mental Health, 2008, 2010; Slade, 2009), and that the systematic reinforcement of the basic human qualities highlighted in the Francis report may be an effective intervention for culture change. We would suggest that these are priority areas for further research and development.

We plan to roll out service user rated experience measures more widely across the Trust and examine good and poor practice in more detail. This is likely to involve the recently developed short version of the INSPIRE questionnaire (n = 5 items) (Leamy, Bird, Le Boutillier, Williams & Slade, 2011), as well as a locally developed measure. Shorter PROMs will be valuable in gathering service user rated assessments of recovery and healthcare on a larger scale, and may be built into routine service audit, where shown to be reliable and valid measures.

The literature is quite clear that culture change is essential if we are to support people’s ability to live independently and well, in the context of serious mental ill-health. We need to move from a traditional hierarchical approach in which service users are cast as passive recipients of expert care, to healthcare models in which the person is supported to direct his or her recovery from a position of inherent authority. The question now is how to deliver effectively on this aim. The Centre for Mental Health describes attitudinal and behavioural changes at both individual (Shepherd, Boardman & Slade, 2008) and organisational levels (Sainsbury Centre, 2009; Shepherd, Boardman & Burns, 2010) necessary to affect such change. Systematic governance arrangements are needed to ensure that agreed principles of healthcare are translated into day-to-day practice and link to improved outcomes, particularly in the current economic climate. A full discussion of what constitutes evidence-based quality indicators for recovery, and a range of possible outcome measures, has recently been published and encourages providers and commissioners to come to local agreements on routine measures used (Shepherd, Boardman, Rinaldi & Roberts, 2014).

We would argue that the systemic change now urgently required in the NHS is dependent on our collective willingness and commitment to co-produce and co-deliver recovery-oriented services, and the routine measurement of linked outcomes. One of the next challenges for mental health care delivery is how we move beyond traditional service user involvement to true partnership working where services are designed, delivered and evaluated by professionals, service users and families working together (Shepherd, Burns & Boardman, 2010).

Recovery-based practice is not simply a means to an end of symptom alleviation or other traditional notions of cure. It involves the development and delivery of services that the evidence base suggests are most likely to support people’s ability to live well independently, even in the context of serious mental ill-health. This requires us to co-produce services and evaluate the impact on recovery outcomes specifically. The present pilot indicates that this is entirely possible.

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Katherine Newman Taylor, Lesley Herbert et al.

References


UNIVERSITY OF LEEDS

LEEDS AT FIFTY!

The University of Leeds Postgraduate Clinical Psychology Programme is celebrating its 50th birthday on the weekend of 10–11 July 2015. All former students, their partners, clinical supervisors, staff members and general friends of the course are warmly invited to join the party.

Friday 10 July
- Afternoon conference – presentations by alumni from across the decades.
- Evening drinks and canapé reception.
- Gala dinner.

Saturday 11 July
- Dales walking and other activities.
- Evening buffet and band.

Accommodation available in Storm Jameson Court on the university campus.

Last date for booking: 15 May 2015

For further details of programme and fees go to: http://medhealth.leeds.ac.uk/info/618/clinical_psychology_dclinpsychol or e-mail D.Williams@leeds.ac.uk
This self-help book for people who hear distressing voices begins by normalising the experience and dispelling the myth that voice hearing is an experience reserved for the severely unwell. The authors empathise with the distress that voices can cause but also present evidence that this experience can be improved. This message of hope and control is an important one and something that I believe is crucial to people starting to feel better about themselves and their experiences. This theme is supported throughout the book with case studies and real life stories. In particular, readers are introduced to ‘Martin’ who hears distressing voices, and his story is followed throughout the book as we start to understand his experience and what helps him.

Part 1 of the book aims to help the reader understand their distressing voices from a cognitive behavioural perspective. The different life experiences that could be a precipitating factor are outlined and the importance of the interaction between people’s thoughts about their voices, their feelings about them, and their reactions to them are carefully described. Questionnaires are provided to help readers establish specific areas of difficulty and provide a means to measure the impact of any changes that they make. Parts 2 and 3 encourage the reader to respond differently to their voices. Part 2 is dedicated to different coping strategies. Part 3 guides the reader to evaluate their beliefs about themselves and the voices, and provides tips for improving their relationships with others (including voices). The rationale for making changes is clearly described, with links to earlier parts of the book and step-by-step instructions are provided with helpful prompts and exercises to complete. In Part 4 readers are encouraged to reflect on any differences that they have noticed from the changes that they might have made.

The final part of the book is written for carers of people that hear voices. This is a useful addition and hopefully it will encourage readers to share what they have learnt with people close to them. I have enjoyed using the book with clients and they have
commented on its clarity, and particularly valued reading the real life experiences. I also think this book is a great resource for people who want to start making some changes to their voice hearing experience on their own or with the support of those close to them.

Katherine Pugh
Katherine is a clinical psychologist interested in working with people with psychosis, using predominantly CBT approaches. She has worked on research trials and provided teaching and supervision in this area. She currently work for Sussex Partnership NHS Foundation Trust in the R&D Department and the Early Intervention in Psychosis Service.

Overcoming Distressing Voices:
A self-help guide using Cognitive Behavioral Techniques
Mark Hayward, Clara Strauss & David Kingdon

Review by: Alina Hsu

The tone of this guide is respectful throughout, and the terminology is simple and humane; it is suitable for use by people who may never have engaged with mental health services, as well as those who are in treatment of some kind. The authors have a balanced view of the causes of voice hearing, and point out that people for whom voice hearing is not distressing tend to have good, supportive relationships with friends and family members, and tend to feel more in control. This is one of the better CBT guides I’ve seen.

The guide applies to people whose voices cause them distress. Overcoming that distress involves changing the relationship with voices by being assertive, which may require work on self-esteem, anxiety, and beliefs – all of which are addressed in the guide. Changing our relationships with voices supports, and is supported, by changing relationships with other people, so this all adds up to improved quality of life (if a particular voice hearer shares that definition of quality of life).

While this guide may be a valuable tool for some voice hearers for a period of time, it will not be appropriate for others, and completing the guide will, in general, not constitute recovery.

CBT acts like a funnel, guiding everyone to a similar state via a predefined path. It is also tendentious: we are supposed to be critical of and challenge our old beliefs, but only look for supporting evidence for the kinds of beliefs the guide endorses. Some people might need a different path, or even a different end state. The result is that CBT can feel manipulative rather than empowering. Yes, it manipulates us purportedly in our own interest, but that interest has been defined by someone else. Many people I have met in the Hearing Voices Network object to CBT for this reason.

In terms of changing relationships, assertiveness is just a beginning. There are other, richer, ways to move the locus of control from the voices to the voice hearer: negotiating, asking questions, showing compassion, noticing that as we relate or behave differently, we can affect our voices, so that the voices themselves evolve.

At a larger scale, finding meaning in the experience of voice hearing is often essential to recovery. By ignoring the content of voices, and our need for meaning, CBT may lead to a state which is not resilient to future challenges.

Alina Hsu BS, MIT; MA, NYU
Alina has lived experience and facilitates a Hearing Voices group. She is active in a variety of community building initiatives, including sustainable practices, ecosystem preservation, post-growth economies, and food sovereignty. She supports the explicit inclusion of people with extreme experiences in all of these areas.
Key issues on the DCP agenda include: the NHS’s *Five Year Forward View* and our response to it; our profile in the new primary care structures and the next phase of IAPT; the Society’s recompense and sub-systems reviews; raising our English and UK-wide policy profile; our 50th birthday celebrations; workforce planning; implementing the new arrangements for our Experts by Experience (EBE) strategy; and last but by no means least, the next steps with regard to our work on diagnosis, equality, inclusion and diversity.

All these matters and more were discussed and progressed at our latest UK Executive Committee meeting in Manchester. The full minutes can be found on the DCP website (www.bps.org.uk/dcp).

**The Five Year Forward View, its Welsh Scottish and Irish equivalents, and workforce planning**

It was agreed that a large part of our annual strategy meeting in May will be used to pull together our collective strategic response. This workstream links closely with the project we have commissioned on workforce planning. Led by Alison Longwill, this project will improve our workforce data and inform important decisions about the future psychology workforce. We are going to be working closely with heads of psychology, the training courses and the Division of Neuropsychology to establish an accurate picture and to develop a robust workforce planning model for clinical psychology, building on any best practice identified, to predict current and future demand and supply factors for clinical psychology. We have established a section on the DCP website for regular updates on this project.

**Development of a DCP Research and Development Unit**

As highlighted in last year’s strategic review, the DCP does not currently provide a coordinating focus for research. The Executive Committee agreed to establish a Research Unit to embed research and research culture into the DCP. Initial start up funding was agreed. This work is being led on the Executive Committee by Reg Morris.

**Experts by Experience**

At the Executive Committee meeting Ruth Stocks, DCP Scotland Chair, and Jo Hemmingfield, our lead for EBE in England, used the the National Survivor User Network (NSUN) National Involvement Partnership Standards (www.nsun.org.uk/assets/downloadable-Files/4pi-ni-standards-for-web.pdf) to help us look at the next steps in the development of our strategy. The 4PI *National Involvement Standards* for the involvement of service users and carers in mental health and social care services are well worth downloading. We will be advertising shortly for service users and members to join the new group that will be coordinating our new EBE work programme.

**Equality, inclusion and diversity**

Stephen Weatherhead leads this work on the Executive Committee. He presented an update on progress to date. Our strategy and details about the way we are developing it are detailed on the DCP website.

The committee debated a request to reopen the Faculty of Race and Culture. This created an opportunity for the Executive Committee to consider its position and ask some important questions of itself. It is
important to note that as the DCP’s race and culture network was constituted as a faculty, it was subject to all the constitutional requirements associated with that. For example, it is necessary for such groups to be quorate at certain meetings. Whilst the faculty was important, it was unable to meet the constitutional requirements, putting its position in jeopardy. Whilst there were some positive elements and some very good output, the faculty could not maintain viability. We considered this again in the context of our increased focus on issues of inclusivity and diversity. Our new strategy and policy development is engaging with a large range of stakeholders. Our aim is to build a truly collaborative framework. This work is due to be completed this autumn. Given this development the committee did not think it would be the right time to re-open a race and culture faculty. The new strategy and policy will include new structures to support members of minority or marginalised groups. We want to learn from the past and ensure we create structures which are sustainable, flexible, active and create space to support people from a whole range of backgrounds.

Understanding Psychosis and Schizophrenia
This publication has received attention around the world and some very positive reviews. You can view some of these these on the DCP website. We agreed at the Executive Committee that we would fund additional work to follow up on the publication. Events promoting it are timetabled for conferences in New York and Milan. We always saw this project as setting new standards for our publications and the way we promote them. It has set the bar pretty high and we are actively looking at the lessons about how we can strengthen the way we commission and manage our publications.

Richard Pemberton
dcpukchair@gmail.com
@socratext

DCP CPD workshops 2015

<table>
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| Approaches to Assessing Early Parent-Child Relationships  
Dr Robin Balbernie, Dr Pauline Lee, Professor Paul Ramchandani, Dr Jill Domoney,  
Professor Hilary Kennedy & Dr Penny Rachett  
Faculty of Perinatal Psychology  
[www.bps.org.uk/2015cpd101](http://www.bps.org.uk/2015cpd101) | 12 May   |
| Parenting Across Cultures  
Dr Iyabo Fattimilehin CPsychol AFBPsS, Amira Hassan CPsychol & Dr Aneela Pilkington  
Faculty for Children, Young People and their Families  
[www.bps.org.uk/2015cpd047](http://www.bps.org.uk/2015cpd047) | 1 June   |
| Peer Group Supervision: A structured model for facilitation of community working and professional development  
Professor Jacqueline Akhurst CPsychol ABPsS  
[www.bps.org.uk/2015cpd052](http://www.bps.org.uk/2015cpd052) | 15 June  |
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‘The selection of papers suits my eclectic mind perfectly, and the quality and clarity of the synopses is uniformly excellent.’
Professor Guy Claxton, University of Bristol
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