PULSAR Manual

Recovery-promoting relationships and working practices for specialist and community mental health services (or Secondary Care staff)

Second Edition (2016)

Adapted for Australian use from REFOCUS

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MONASH University

PULSAR
principles unite local services assisting recovery

SOUTHERN SYNERGY

Contents

Preamble to the Australian PULSAR Project

The PULSAR project is an Australian training and research project funded by the Victorian State Government's Mental Illness Research Fund (MIRF). PULSAR is based on the Refocus program from the UK. This project is testing a practical approach to address the vital issue of how different types of services within a defined geographical area can be refocused to support recovery for people with mental illness. It is expected to shed light on how clinical mental health, primary care and community support services can collaborate effectively and support people with mental illness achieve their personal recovery goals. The research will adapt and test the usefulness of a set of training materials and organisational change techniques first used in the UK, with particular focus on how they can be suited to the Victorian context

Australia, and particularly Victoria, has seen the development of recovery focussed services in recent years. This project is adapting the Refocus material to take into account the characteristics of Victoria's service system, comprising of multiple service providers including clinical and community managed mental health support services (specialist mental health services or secondary care) and General Practitioners (GPs), or primary care providers. A separate manual has been developed for primary care. One feature of Victoria's mental health services that contrasts with the United Kingdom is the relatively high use of Community Treatment Orders (CTOs). The Mental Health Act (2014) has introduced mechanism's to minimize compulsory treatment, promote recovery and increase supported decision making. The introduction of Advance Statements and Nominated Persons schemes in conjunction with the Mental Health Complaints Commissioner and the Mental Health Tribunal are envisioned to support a Recovery Focused system. Working with people in the context of these new laws and service delivery systems will be considered in greater detail in the PULSAR Active learning Sessions (PALS).

More information on the Victorian Framework for Recovery Orientated services and the Mental Health Act (2014) can be sourced from
http://www.health.vic.gov.au/mentalhealth/

Direct Care/Support Delivery participants

Agencies and people involved in the support of people with a mental illness who are associated with the PULSAR Recovery project include:

- **Mind Australia**
- **Ermha**
- **Monash Health**
- **Primary Health Care**

The direct care participants are also key research participants in the project.

A note on Language

People who use mental health services in Australia are referred to with a variety of words and phrases in documents. It is still a point of contention on the most appropriate way to refer to people. For the purposes of this document, and in recognition of the work undertaken by consumer activists in the 1980's to change the way consumers where referred to, we will use the term consumer to identify any person with an experience of a diagnosis of mental illness, who uses mental health services, or who might otherwise be included in this group.

Consumers have many people who are a part of their lives apart from service providers. These include family, friends, and community members. For the purpose of this document we will refer to the people that provide support to consumers as Family and carers.

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The Development of Recovery in Mental Health in Victoria

The term recovery as a specific concept in mental health care was coined over 20 years ago and has a long history in Victorian Mental Health Services. Recovery was first formally recognized in the Australian National Mental Health Strategy in the 2003 – 2008 National Mental Health Plan[1]. The Victorian (in 2011[2]) and Commonwealth (in 2013[3]) Governments released framework documents aimed at facilitating the development of evidence-based recovery oriented mental health services with a focus on 'personal' recovery. From 2014 forwards a new Mental Health Act in Victoria supports a recovery oriented approach.

Executive Summary of the PULSAR Project

This manual is based on the REFOCUS Manual developed by Professor Mike Slade at Kings College London. The manual was discussed widely by Chief Investigators of the Australian PULSAR Research project and considered in consultation with primary and secondary mental health care staff. It describes an intervention aimed at increasing the focus of primary and mental health community staff in Australia to support personal recovery. The intervention is designed to be incorporated into the services model of care and has two components: Recovery promoting relationships and Working practices.

Recovery-promoting relationships

The working relationship between staff and consumers is central to personal recovery. Developing and supporting this relationship will involve:

- Developing a shared team understanding of personal recovery

- Exploring values held by individual workers and in the team

- Skills training in coaching

- Raising the expectations held by consumers that their values, strengths and goals will be prioritised.

Working practice 1
Understanding values, treatment and support preferences

To ensure that care planning and service provision actions are based on the consumer's values, treatment and support preferences, this working practice involves:

- Consumers discussing their values, treatment and support preferences with mental health staff

- Recording these values, treatment and support preferences on the clinical or service record information system.

Working practice 2
Assessing strengths

To ensure care planning is focussed on amplifying a consumer's strengths and ability to access community supports, this working practice involves:

- Consumers identifying their strengths with staff using the strengths assessment worksheet

- Recording these strengths on the clinical or service record information system.

Working practice 3
Supporting goal-striving

To ensure care planning is oriented around personally valued goals and that staff support active goal-striving, the intervention involves:

- Consumers identifying their personally valued goals with staff

- Recording personally valued goals on the clinical information or service record system

- Staff supporting consumers in striving towards their goals.

Implementation strategies

Three implementation strategies will be used:

- Personal recovery training

- Team manager reflection group

- PULSAR Active learning sessions (PALS)

Chapter 1: Overview

This PULSAR manual describes a pro-recovery intervention and how it can be implemented by staff working in community mental health teams.

1.1 Purpose of the Personal Recovery Training

The primary aim of the PULSAR training (the intervention) is to support personal recovery. This will involve striving towards consumers goals, with partnership support where needed from staff. The type of support and the way it is provided by staff will be guided by the person's unique strengths, values, and treatment or support preferences.

1.2 The training

The training comprises of 2 days training and is supported by 12 sessions of reflective learning and practice provided to teams on a monthly basis. The training has been designed to impact in two ways: *how* staff and teams work with consumers, and on *what* consumers and staff discuss and actually do. We call these 'recovery-promoting relationships' and 'working practices' respectively. So the training has two components:

A. Recovery-promoting relationships

- Training and reflection opportunities will be offered to teams to allow them to enhance their understanding of what personal recovery means in their practice context, to consider their own values and how these can support recovery, and to develop and practice the use of coaching skills.

- Consumers can be active agents in shaping the content of conversations with mental health workers. Consumers will be supported to develop expectations that their values, strengths and goal-striving will be prioritised.

B. Pro-recovery working practices

- Understanding consumer's values, treatment and support preferences underpins an individualised approach to care and/or support planning.

Workers will learn and develop practices for understanding values and encouraging people to express their values.

- Amplifying a person's strengths and ability to access community supports is an important approach to supporting recovery. Workers will learn and develop practices for using assessing strengths.

- Identifying personally valued goals, developing intermediate steps, and striving towards these goals contribute to recovery. Workers will learn and develop practices for using existing care and/or support planning skills to support goal-striving.

These two components are inter-linked. The relationship is central – it's not just what you do, it's how you do it. The working practices will only support recovery when undertaken in the context of a recovery-promoting relationship.

Staff working in specialist mental health services and community mental health services already have a range of skills for supporting personal recovery, some of which may be outlined in this manual. The intervention has been designed to allow workers to recognise and build on their existing skills and expertise. The intervention deliberately maps onto existing care and/or support planning processes and reinforces those parts of current practice which best support recovery. Staff who already have expertise in these areas can make an important contribution in supporting others to develop pro-recovery skills, by modelling best practice and supporting implementation.

Relationships are at the heart of the intervention. Recovery-promoting relationships involve consumers and staff working together as partners. Within this relationship, staff use their mental health expertise as a resource for the individual as they try to find ways forward in their life. This can be summarised as services being *'on tap, not on top'* [1], and may involve consumers and staff learning together about new ways of relating to each other. For staff, recovery-promoting relationships involve awareness about their own values and beliefs, knowledge about recovery, and skills in using coaching to relate to the person as an expert-by-experience. The early part of the intervention is focussed on developing these practices that underpin these changes.

The approach to recovery-promoting relationships is described in Chapter 2, which covers:

- Core knowledge about personal recovery

- Recovery-supporting personal values and beliefs

- Shared team pro-recovery values

- Coaching skills to underpin each working practice

- Raising expectations held by people using the service.

In the context of a recovery-promoting relationship, three specific conversations/behaviours support recovery. These are called **working practices**.

Working practice 1: Understanding values, treatment and support preferences

Recovery-orientated services are focused on an understanding of people's values, beliefs and preferences, both in general and specifically in relation to treatment and/or support. This may involve learning more about their life story, support with the development of a personal narrative, and finding out about the individual's values. This is needed for a person-centred approach to care planning and recognises that individualised care planning takes place within a social context.

Understanding the person's values is described in more detail in Chapter 3.

Working practice 2: Assessing strengths

Recovery is supported by recognising and building on the individual's strengths. This involves learning about the strengths and positive attributes of the person, as well as the supports and positive connections in their life. Identified strengths might include any skills or knowledge gained through formal education, training or work, and through other life experiences, as well as personal strengths such as resilience, optimism, artistic skills, compassion, an interest in nature, a supportive family, a positive cultural identity, or knowing the local area. The aim is to ensure a holistic understanding of the person, in which the persons strengths as well as deficits are identified.

Assessing strengths is described in more detail in Chapter 4.

Working practice 3: Supporting goal-striving

This working practice maps onto the direct service process of care and/or support planning. It involves identifying the individual's goals, and then supporting the individual as they work towards them. There is an emphasis on:

- Identifying personally-valued goals

- Planning actions orientated around the person's values and strengths

- An orientation towards supporting the person to undertake actions with and without support from others.

Supporting goal-striving is described in more detail in Chapter 5.

1.3 The PULSAR Program

The intervention is based on the REFOCUS Program, which identifies the intended effects of the intervention. It has four parts: the intervention, the 'practice change' (i.e. the impact the intervention has on the team and staff), the impact on the experience of the consumer, and the beneficial outcomes. The REFOCUS program is shown in Figure 1.

Figure 1: The PULSAR Program

INTERVENTION	**Recovery-promoting relationships** Staff values and knowledge, coaching skills, partnership
	Working practices 1. Understanding values and treatment preferences 2. Strengths assessment 3. Supporting goal-striving

PRACTICE CHANGE		
	Team Values	More pro-recovery norms and values within the team
	Individual Values	More pro-recovery values in workers
	Knowledge	More knowledge about personal recovery
	Skills	More skills in coaching and the three working practices
	Behavioural Intent	Plan to use coaching and implement the three working practices
	Behaviour	More use of coaching and the three working practices

EXPERIENCE OF PERSON USING THE SERVICE		
	Content	More experience of coaching. More focus on strengths, values and goal-striving
	Process	More support for personal recovery

OUTCOME FOR PERSON USING THE SERVICE		
	Proximal	Increased hopefulness, empowerment, quality of life, well-being
	Distal	Improved personal recovery

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Chapter 2: Recovery-promoting relationships

2.1 Relationships contribute to recovery

Relationships between people working in and using mental health services are an important contributor to recovery for many people. Recovery-promoting relationships reflect the worker's pro-recovery values, are underpinned by knowledge, and often use the specific interpersonal skill of coaching.

2.2 What the intervention involves

For the whole team:

- Participation in the PULSAR personal recovery training

- Participation in PALS which will be offered each month over a one year period.

For individual workers in the team:

- Using the Supervision Reflection Form at supervision.

2.3 Values held by the worker

Values underpin all behaviours by mental health service providers. For example, assessment asks about some topics and not others, goal-planning prioritises what matters and any intervention, including a decision not to intervene, reflects values. Clinical or service provision actions often involve placing greater weight on one value over another. A consistent theme in pro-recovery services is that values are both explicitly identified and used to inform decision-making.

Developing relationships which promote recovery will be difficult if the people involved do not hold these values. However, holding to these values can also be challenging. Sometimes consumers say they want things which are hard to understand or even seem harmful, or they say they do not want help even though their lives may seem, to the mental health worker, highly impoverished. The challenge is responding in a way that fits with recovery-supporting values.

This part of the intervention involves workers becoming more aware of their personal and professional values, identifying as far as possible shared recovery-supporting values within the team, and using these values to shape discussion, decision-making and action by the team. Holding these values will be particularly challenging in the context of people who are assessed as not having capacity to make decisions in relation to their mental health care.

2.4 Values held by the team

For individual staff to successfully work in a recovery-orientated way, this needs to be underpinned and supported by shared team values. These values need to explicitly promote recovery orientated practice and all members of staff need to be aware of them. These values are used to guide practice. Leadership will enhance the adoption of these shared team values. The intervention aims to support the development and awareness of pro-recovery team values by:

- Team level personal recovery training

- Team reflection sessions

- Team manager/leader peer support

- Individual reflection as part of the supervision process.

Values held by the team and individuals will be covered in the personal recovery training provided to the team.

Box 1: Three proposed values for a recovery-orientated mental health services [5,6]

Value 1

The primary goal of mental health services is to support personal recovery

Supporting personal recovery is the first and main goal of mental health services. Providing treatment, care and support can be an important contribution towards this goal, but is a means not an end. Similarly, intervening in crisis or addressing risk issues may sometimes need to take precedence, but should be orientated around the primary goal of supporting recovery.

Value 2

Actions by mental health workers will primarily focus on identifying, elaborating and supporting work towards the person's goals

If people are to be responsible for their own life, then supporting this process means avoiding imposing clinical or service provider meanings and assumptions about what matters, and instead offering support which is consistent with the person's values as they work towards their life goals.

Value 3

Mental health services work as if people are, or (when in crisis) will be, responsible for their own lives

It is not the job of mental health workers to fix people, or lead them to recovery. The primary job is to support people to develop and use self-management skills in their own life.

2.5 Knowledge about recovery

Working in a recovery-supporting way involves knowing some things about recovery which include:

- What personal recovery means
- The distinction between personal recovery and clinical recovery
- That many consumers do experience personal recovery
- That recovery can take place within, partly or wholly outside the mental health service
- That there are many ways in which mental health services and workers can support recovery
- That discrimination and stigma can be a barrier to recovery, so
  - language matters
  - beliefs that consumers are fundamentally different from other people are a hindrance to supporting recovery
  - it is more helpful to emphasise the ways in which consumers are no different to everyone else in society
  - other types of discrimination and stigma that consumers are exposed to need to be similarly recognised and acted upon e.g. racism, being a recipient of welfare benefits.

A recovery orientation is evidence-based, although not all the evidence may be familiar to mental health workers. Many workers are familiar with evidence from large groups, such as randomised controlled trials and systematic reviews. The evidence from individuals – personal narratives about recovery – may be less familiar. So a key approach to developing recovery knowledge is being in contact with or learning about individuals who have personal experience of recovery. This includes hearing people's stories and reading recovery narratives.

This will be covered in the personal recovery training provided to the team.

2.6 Coaching

Coaching is a specific interpersonal style that supports recovery.[7,8] The advantages of a coaching approach are:

1. It assumes the person is or will be competent to manage their life. The capacity for personal responsibility is a given.

2. The focus is on facilitating the process of recovery to happen, rather than on the person. Coaching is about how the person can live with a diagnosis of mental illness, not on treating the mental illness.

3. The role of the coach is to enable this self-righting capacity to become active, rather than to fix the problem for the person. This leads to strengths and existing supportive relationships being amplified, rather than of deficits.

4. Effort in the coaching relationship is directed towards the goals of the person using the service, not the coach.

5. Both participants must make an active contribution for the relationship to work.

The use of coaching conversations presents challenges and requires staff to think about the way they work as individuals and as team members. Coaching is not therapy. It is about helping an individual "spring loose" their resourcefulness, build on strengths and make changes to reach personally valued goals. Coaching is a "live", iterative process. It is helpful to contract with the person about their expectations of how they would like to work, the coaching structure and process, expectations of the member of staff who will be working with them, and the "rules of engagement".

The use of coaching conversations requires staff to demonstrate exquisite listening, questioning and feedback skills, and to operate from a belief system that holds people as able to generate their own solutions and be personally accountable for achieving their desired goals.

Coaching is an interpersonal style which will ensure that the three working practices support an individual's personal recovery. This will be covered in the coaching training provided to the team. Throughout the training the Coaching for Recovery approach (outlined below) will be used to help staff apply the three working practices; i.e. (i) Understanding values, treatment and support preferences, (ii) assessing strengths, and (iii) supporting goal-striving.

The Coaching for Recovery approach involves five stages:

1. **Reflect** – this is an active process in which a team member works with a person to enable them to review how they are getting on and, within the sphere of their control, take responsibility for action and change. This requires exquisite listening skills throughout the conversation.

2. **Explore** – this provides the opportunity to explore the issue/problem/task and the options. This requires the use of powerful questions and the skill to acknowledge a person's contribution.

3. **Agree outcomes** – this is important to help focus the conversation and agree the desired results. This part of the conversation may require you to challenge the person to help them "spring loose" their resourcefulness and to empower them to take more responsibility for what they want to achieve. It might at times require a frank or tough conversation, which requires you to use the skill to confront and you may also need to use the skills of permission and intrusion.

4. **Commit to action** – This part of the conversation is essential as it will help the person and you pin down the action that needs to be taken and by when. Goal setting is an integral part of commitment to action.

5. **Hold to account** – This is the closing stage of the conversation and in agreeing how the person will be held to account you may need to give feedback.

2.7 Raising expectations held by Consumers

Consumers can be active agents in shaping the content of interactions with service providers and workers. Work is currently underway to develop supporting materials for consumers using services that are a part of the PULSAR trial. Staff are also encouraged to talk with consumers about the PULSAR trial and this style of working in order to raise the expectations of people using the service and so support this shift towards working in partnership.

In the next three chapters the working practices are described. These working practises are not something the worker has to get done before they can get on with their real job. Rather, understanding values, assessing strengths and supporting goal-striving is the job of a recovery-supporting worker.

Chapter 3: Understanding values, treatment and support preferences

3.1 Understanding values contributes to recovery

Mental health workers, who support recovery, orientate their actions around the values in life, treatment and support preferences of the person using the service. Only when the person's values are shared and inform decision-making will services be working *with* the person (not 'on' the person). Understanding values therefore contributes to ensuring that care and/or support planning is consistent as far as possible with the individual's values. One aim of this working practice is to be able to record information about values, treatment and support preferences on the clinical or service information system.

3.2 What the intervention involves

Workers are asked to do two things:

1. Learn about the values, treatment and support preferences of each person they provide services for.

2. Record an agreed summary of these values, treatment and support preferences on the clinical or service record information system.

3.3 Understanding values to inform the care plan

We all have values, attitudes and experiences which impact on who we are. Being understood as an individual is an important contributor to recovery. Avoiding assumptions about an individual's identity is important, particularly for people from minority communities such as Aboriginal and Torres Strait Island communities, refugee communities or gay, lesbian, bisexual and transgender individuals. In terms of treatment and support, having values, treatment and support preferences discussed, listened to and acted on all contribute to recovery.

An understanding of a person's values, treatment and support preferences is needed if care is to support personal recovery. The process of getting to know a person may involve talking about sensitive areas such as the experiences of discrimination, stigma, racism and previous relationships with services. This process will take time and involve many conversations so trust can be built and boundaries change to allow the discussion of these topics to take place. As people's values, treatment and support preferences may change over time; it cannot be a one-off conversation.

What does understanding values involve? The conversations may involve:

*   Learning more about the individual's life history – where does the person come from and what important influences have shaped their personality?

*   Learning more about their rich identity – considering race, culture, ethnicity, gender, spirituality, sexual orientation, etc.

*   Supporting the development of their personal narrative – what is their story about how they come to be where they are in their life?

*   Understanding values – what matters to the person?

*   Treatment and support preferences – what kind of help does the person want from both mental health services and other sources?

The general principles in any conversation are:

*   Use coaching skills, supporting the development of new learning and understanding in you and the person.

*   Don't assume any particular aspect of the person is or is not important

*   Be respectful of boundaries – the person may not want you to know everything about them

*   Be open to all conversations – give individuals a chance to discuss areas, even if it may be a sensitive topic.

3.4 Developing conversations

Individuals (both consumers and workers) vary in the approach that they find most helpful. Three possible approaches are now described: **conversational, narrative** and **visual**. A combination of the three approaches can be used or other approaches that are appropriate for the individual. Whatever approach is taken, it is important to explain why you are asking these questions or having these conversations. It is also important to actively encourage people to focus on what they would like you to know, and what they particularly value, rather than feeling they have to tell you everything. The agreed summary is then recorded in the Values, Treatment and Support Preferences section of the clinical or service record information system.

3.4.1 Conversational approach

For some people, having an open conversation with the worker may be the preferred approach. We have developed an interview guide to help with this – the Values, Treatment and Support Preferences (VTSP) interview shown in Appendix 1. Questions in the VTSP have been modified from other sources,[9,10] and give a framework for conversations about areas which have been identified as important for people in their recovery journey. The VTSP – like recovery-orientated care-planning – starts with personal values and then considers their treatment and support preferences. It contains possible questions which would be used within a conversation. The intention over time is to work through the topics covered in the interview guide, though not necessarily in the order given.

One helpful approach to start these conversations is that of respectful curiosity – *"I want to work with you in ways which fit with who you are and your values in life, so I'll be interested to learn about whatever you decide to share with me".*

3.4.2 Narrative approach

The second approach to understanding values is to support the person to write their story down and then share it with the worker. Since narratives may be developed wholly or partly outside of meetings, it is important to be clear that not all parts need to be shared with the worker. The person may want to write some bits either just for themselves or to share with family or friends.

One approach to start with is to give the person a blank copy of the VTSP interview guide as a template. Alternatively, suggesting the following questions or themes may be helpful:

- Your life so far, including significant positive and negative life events

- What is important to you?, What things in your life do you value?

- How would you describe yourself to another person? E.g. your background, your values, beliefs and experiences

- How have your mental health experiences shaped your life?

- What makes your life meaningful?

- What has helped or would help you on your recovery journey?

- What things have had a negative effect on your wellbeing and recovery journey?

- How would you describe your mental health experiences, what have you learned from your experiences?

- I know people respect me when…

The Scottish Recovery Network has a section on their website for people interested in writing narratives (www.scottishrecovery.net). The website includes a number of narratives as well as writing tips. Other resources are listed in Appendix 4.

3.4.3 Visual approach

The third approach to understanding values is to support the person to create life maps. These are based on mind-mapping approaches, and have been developed as person centred planning tools that offer one way of finding out about an individual's values and treatment and support preferences. They can be completed in partnership with the individual and can use a variety of different media including photographs, pictures and words. They can also take many forms, including those suggested below. Some people find having a template a helpful way to start. Template life maps are available on web-sites listed in Appendix 4.

Common life maps (modified from elsewhere[11]) include Relationships, Background, Who am I?, Preferences, Choices, or Respect maps. Some or all of these may be combined in a single map, or the focus may be on just one area or map at a time.

Relationship Map

The relationship map can be divided into sections such as family, friends, community, and mental health staff or providers. People can place pictures or words of individuals who are important or close to them on the map.

Background Map

This map focuses on what life has been like for the person. Many people find it helpful to include a timeline usually from birth to the present time and record events and experiences which they feel have been significant. The timeline may include positive experiences and achievements as well as times of trauma, loss and grief.

Who am I? Map

This map may be used to find out about areas of a person's identity which are important to them and their treatment and support. Individuals may wish to include sections for ethnicity, gender, culture, spirituality etc. as well as other areas important to them. The VPT interview guide may be a useful tool for some people to help identify important areas to include.

Preferences Map

This map describes the person's personal preferences, interests and gifts. It may be linked to many of the other maps, particularly the Background and Who am I? maps. People should be encouraged to include what they like as well as dislike. Although this may be related to mental health services, this doesn't have to be the case.

Choices Map

One way to draw the Choices map is to divide a page into two, with one half representing the decisions the person makes in their life, with the decisions made by other people in the opposite half. This map could also be used to demonstrate areas in which individuals would like more control over their life, and the barriers they may face (re)gaining this control.

Respect Map

One question that may be included in this map is "I feel respected when…". It may also be used to highlight times when the person has and hasn't felt respected and to illustrate what the person respects and values about themselves and others. Some people also chose to include barriers to respect in their maps.

Chapter 4: Assessing strengths

4.1 Assessing strengths contributes to recovery

Health is more than the absence of illness, therefore supporting recovery involves more than treating mental illness. It involves identifying and amplifying an individual's strengths.

What is a strength? The term means internal and external resources available to the person.

An **internal resource** is something positive about the person, such as personal qualities, characteristics, talents, knowledge, skills, interests and aspirations. Strengths may include any skills or knowledge gained through formal education, training or work experience, as well as personal strengths such as hope, feeling empowered, being optimistic, having compassion, being a good listener, having artistic skills, having an interest in nature, having a positive cultural identity, being fit, having survived tough times, having strategies that have previously worked for the individual or having experienced periods of well-being.

External resources are anything which helps or could help the person *in their life*, and includes respected role models, a supportive family, having enough money, being well-connected in the local area, having a friend, having somewhere to go in crisis, having a good relationship with neighbours, undertaking voluntary or paid work, having a decent place to live, and involvement in collective activities (e.g. singing in a choir). External resources may also include **service resources** – which are ways in which mental health and other services can help the individual, either in the way they work with people (e.g. holding hope for the person) or in the content of care (e.g. offering effective treatments and support).

The purpose of assessing strengths is to develop a holistic understanding of the person. Addressing problems such as symptoms through using service resources e.g. medication, cognitive-behavioural therapy etc. may support many people's journey of recovery.

However the evidence from many sources (e.g. well-being and mental capital research, positive psychology, syntheses of recovery narratives, randomised controlled trials of consumer-operated services) is consistent that supporting the person to live life as well as possible involves more than just treating illness. It also – and for some people mainly – involves supporting the person to grow and develop.

4.2 What the intervention involves

Workers are asked to do two things:

- Learn about the strengths of the person they provide services for

- Record an agreed summary of these strengths on the clinical or service record information system.

4.3 Undertaking a strengths assessment

A good assessment[12] is:

- **Complete** – each life domain has rich and detailed information

- **Individualised and specific** – gives a clear picture of who the person is

- **Reflects the full identity** of the person, including where relevant culture, spirituality, sexuality and gender

- **Partnership-based** – there is clear indication of the person's involvement, including personal comments, information written by the person, and in their own words

- **Includes external resources** – rather than just internal resources or service resources in each area, i.e. considers the person in their life, not in isolation

- Captures the person's **skills, talents, accomplishments and abilities** – what they know about, care about and have a passion for in each life domain.

- **Up to date** – clear when last revised and sufficiently current to be useable.

Assessing strengths involves[13]:

- Listening to the person's understanding of the facts

- Believing the person

- Discovering what the person wants

- Assessing different dimensions of a person's strengths

- Using the assessment to discover uniqueness

- Using language the person can understand

- Making assessment a joint activity between the worker and the person using the service

- Reaching a mutual agreement on the assessment

- Avoiding blame and blaming

- Avoiding cause-and-effect thinking

- Assessing, not diagnosing.

The strengths of a person can be assessed in a number of ways. Training will be provided in one particular approach – the Strengths Worksheet – but other approaches can also be used.

The Strengths Worksheet (appendix 3) is a tool to help workers to identify and use the strengths, resources, talents and abilities of the person. The tool covers six life domains: Daily living situation, Financial, Occupational, Social Supports, Health, and Spiritual/ Cultural. It is supplemented with a Strengths Worksheet checklist (shown in Appendix 4).

The agreed summary is recorded in the Strengths section of the clinical or service record information system.

Chapter 5: Supporting goal-striving

5.1 Supporting goal-striving contributes to recovery

Recovery is supported in two ways when individuals work towards their goals. First, and most obviously, achieving personally valued goals is a positive experience. Second, and perhaps even more importantly, the process of goal-striving brings many benefits:

- Hope is increased through the experience of trying to improve life

- Agency is increased through learning how to make progress towards goals

- Resilience is increased through overcoming the inevitable set-backs

- Empowerment is increased through learning how to be in the 'driving seat' of one's life.

5.2 What the intervention involves

Workers are asked to do three things:

- Learn about the personally valued goals of the people they support

- Work in partnership with the person in support of these goals

- Record an agreed summary of the goals and associated care plan on the clinical or service record information system.

5.3 Goal-striving principles

Mental health workers have substantial experience in care planning, and these skills are used in supporting goal-striving. Six principles identify the possible points of difference from traditional care-planning approaches:

1. Goal-striving is supported by coaching

Coaching is a helpful way of working which avoids making decisions for the person. The GROW Model[14] offers a useful framework that prompts the coach about seeking clear outcomes and about the steps needed for change to take place.

Goal for coaching style interaction – where do I want to be? What do I want to happen? Start with a vision of what it will be like when you have reached the goal, and then get more specific.

Reality – what is the situation now? Ask specific questions about who, what, where, how much.

Options – What's possible? – what options exist to get closer to the goals?

Wrap-up – Gain commitment, clarity and support and 'wrap-up' by agreeing next steps and how these will be taken forward.

Another model that can assist with Coaching is REACH

Reflect – on values, preferences, dreams and aspirations. If previous goals have been agreed on, what is the current situation/outcomes/progress?

Explore – dreams and aspirations, what are the options, possibilities and decisions that need to be made.

Agree Outcomes – what is the end goal that is agreed on, think about using SMART (specific, meaningful, attainable, realistic and timely).

Commit to action – agree what each person is going to do, how they could achieve it and what is the timelines. In addition to the worker and the person this may include family, friends and other support structures.

Hold to account – have clear guides as to what is accountable by each person. At next meeting discuss what has been achieved and link to Reflect.

Both **GROW** and **REACH** are cyclic in nature, that is you may do each section several times in each meeting. It also may not be possible or appropriate to undertake each section every time you meet with the person. For instance on a first meeting you will not be able to hold to account as no actions have previously been agreed upon.

2. The person's goals are the primary focus of action planning

Some plans may address goals needed for other reasons (e.g. addressing risk or child protection issues), but the focus should be integrating these actions while supporting personally valued goals.

3. Approach goals are more achievable and sustainable than avoidance goals

An approach goal involves a positive change towards a better life, whereas an avoidance goal involves avoiding something negative happening. This is partly reflected in how goals are expressed – "I want to reduce my medication" (avoidance goal) versus "I would like use other strategies besides medication to manage my illness" (approach goal). Or "I want to lose weight" versus "I want to dance again". It is also about how the goal is developed – having a vision of a better life is more useful in supporting hopeful goal-striving than focussing on trying to stop bad things happening.

4. Goal-striving is based on the person's values, treatment and support preferences

There are many ways to work towards goals. The plan should clearly reflect the individual's values – their way of working. For example, the pace of progress, the level and type of support from others, the extent to which mental health workers feature, will all vary from person to person. Specifically, it may be that the worker and person using the service develop goal steps which do not involve any action from mental health workers.

5. Goal-striving builds on strengths

Building on existing internal and external resources is a powerful approach to supporting recovery. It sends the message that the person is not deficient and in need of fixing, but rather has the capacity over time to self-manage. The person's strengths should be visible in the care plan as a resource to be used and amplified. For example, for someone attending a college course, a goal building on this strength may be "I would like to continue to build my confidence in meeting new people at college".

6. Actions should focus on supporting the person to do as much as possible for themselves

Care plans may involve:

- **Independent action** – the person doing things for themselves

- **Joint action** – doing things with other people, especially family or friends or community resources, but also including actions with the mental health worker

- **Passive action** – workers doing things for the person.

Passive actions by workers may inadvertently hinder the development of self-management skills. The job of the worker is to support the person to learn, over time, the skills to do things either for themselves or with support from others. Making progress through joint and independent actions leads to increased hopefulness, confidence and resilience. Action by workers is of course sometimes needed, but the more workers can support independent or joint action, the better.

5.4 The process of supporting goal-striving

As in standard care planning processes, this involves the steps of identifying goals, planning actions, and then implementing the plan.

Identifying goals

Some people will be able to identify their personal goals easily. For others, identifying valued goals will be more difficult. Some people will not be familiar with the idea of having goals, or may not feel that they are able to set goals. People who use mental health services may feel they cannot achieve any goals, for example due to hopelessness, discrimination they have faced and internalised, or perhaps even the low expectations of mental health services in the past. Asking people to identify goals can bring up issues about control in life, and remind the person of times when they feel they have failed. The process of helping to identify goals needs to be done sensitively and may involve many sessions and the development of a trusting relationship. The relationship is therefore key for people to feel able to express what often are very personal dreams and hopes for the future.

Ways to start this conversation include:

- *What would make your life better?*

- *Thinking about the strengths you have identified, is there something you would like to build on?*

- *How would you feel about trying something new? What might that be?*

- *Is there something you've always wanted to try or do, but never had the chance to? Would now be the time to try it?*

Planning actions

Once the goal(s) have been identified, the next step is to work together as partners to identify steps towards those goals. This will involve:

- The person themselves prioritising the goal(s) to focus on

- Identifying their strengths which are relevant to the goal(s)

- Identifying how their values, treatment and support preferences will impact on the action plan

- Breaking goals down into discrete manageable steps specify who will do what and when, either informally or using the SMART (Specific, Meaningful, Attainable, Realistic, Timetabled) approach

- Supporting the person to undertake independent or joint actions rather than accepting passive actions.

The resulting care plan will:

a) Focus on personally-valued goals;

b) Reflect the person's values, treatment and support preferences;

c) Build on the person's strengths; AND

d) Involve independent and joint action rather than passive action.

This care plan is then recorded on the clinical or service record information system, and implemented. An example of a personally valued goals clinical or service record information system entry is shown in Appendix 5.

Chapter 6: CHIME

6.1 Development of CHIME

Chime is a conceptual framework for recovery that was developed following a systematic review of literature by researchers[15] from the Refocus Research Team. Leamy et al (2011) undertook this review utilizing a modified narrative synthesis, involving a systemic search that identified 5208 papers from which a total of 97 papers were included for analysis of factors in personal recovery. The development of the framework included consultations with service users, clinicians and academics with expertise in mental health.

The conceptual framework that emerged from the review consisted of:

A. 13 characteristics of the recovery journey; (Table 1)

B. five recovery processes comprising: connectedness; hope and optimism about the future; identity; meaning in life; and empowerment (giving the acronym CHIME) (Table 2)

C. recovery stage descriptions which mapped onto the trans-theoretical model of change.

Table 1: Characteristics of the recovery Journey[15]

Characteristics	Number (%) of 87 studies identifying the characteristics	
Recovery is an active process	44	(50)
Individual and unique process	25	(29)
Non-linear process	21	(24)
Recovery as a journey	17	(20)
Recovery as stages or phases	15	(17)
Recovery as a struggle	14	(16)
Multidimensional process	13	(15)
Recovery is a gradual process	13	(15)
Recovery as a life-changing experience	11	(13)
Recovery without cure	9	(10)
Recovery is aided by supportive and healing environment	6	(7)
Recovery can occur without professional intervention	6	(7)
Trial and error process	6	(7)

Table 2: Deductive coding framework[16]

Super-ordinate category	Subordinate category
Connectedness	Peer support and support groups Relationships Support from others
Hope and optimism	Hope-inspiring relationships Motivation to change Belief in the possibility of recovery Positive thinking Having dreams and aspirations
Identity	Dimensions of identity Rebuilding/redefining a positive sense of identity Overcoming stigma
Meaning and purpose	Meaning of mental illness experience Spirituality (including development of spirituality) Quality of life Meaningful life and social goals Meaningful life and social roles Rebuilding of life
Empowerment	Personal responsibility Control over life Focusing on strengths

6.2 CHIME Framework

There have been studies[16] of the CHIME framework that explore in detail the appropriateness of the framework from consumers perspectives. The following in depth exploration of each theme with in CHIME is adapted from a key publication by the original authors in 2014 entitled *Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers* (Bird et al 2014).

6.2.1 Connectedness

During the systemic review connectedness emerged as a very important process in recovery and was defined as activities that incorporate peer support, support from others, and a variety of relationships with friend, family and professionals.

Peer support and support groups. Many different groups were identified as offering support to individuals, including close family friends, members of the community and mental health professionals. Peer support was particularly identified as important with participation in groups and contact with peer support workers frequently emphasised.

> *'Like I said before you know they're organising a group, hearing voices groups and um, it's very helpful. We meet … every Thursday and we share our experiences with each other and it has helped a lot.' (Leicester FG2, female participant)* (Bird, 2014 p 647)

Support from others. Having a range of personal relationships with others was critical for participants and it was noted that for some connectedness was more than immediate family and friends and included feeling part of society.

> *'You're not recovered if you no longer cut your wrists or take an overdose … that's not a life. For most people you're recovered if you have friends, if you have family or if you have a job.' (SLaM FG1, female participant)* (Bird, 2014 p 647)

Relationships. Finally, the sense of personal relations with supportive and collaborative professionals was seen as having a positive impact on recovery.

> *'Whereas I've got this nurse who sits down and listens to what I have to say …, gives me her opinion of things and provides with the right medications for me. That has helped me recover quicker.' (Gloucester FG2, female participant)* (Bird, 2014 p 647)

6.2.2 Hope and optimism

Many participants identified hope as especially important in the early stages of recovery where people described experiencing reawakening of hope after despair. Hope was emphasised by the idea that recovery is an active process, not something that is done to the person.

> *'Yeah, but hope is one of those things that you have to do yourself. No one's going to hope for you, really. And optimism, because there is a lot of optimism.' (Gloucester FG1, male participant)* (Bird, 2014 p 647)

Hope-inspiring relationships. Central to defining hope was the presence of hope-inspiring relationships. Hope inspiring relationships could be with family, friends and professionals or with a higher power, and all shared the common characteristic that they engendered a belief that recovery was possible. For some participants, peers provided this hope for the future.

> *'The employment specialist, she was an ex-patient and I find that a real positive. It makes me realise there's hope, because I never thought there was hope. I thought I just can't get a job, but there is hope, y'know.' (SLaM FG3, male participant)* (Bird, 2014 p 648)

Equally powerful was the evidence that emerged of how professionals could reduce hope and the belief in recovery.

> *'Well for me, when I got struck down with the mental illness, I went to the usual psychiatrist and they told me, "Ah. This is a chronic illness. That means you will have to live with it." So the recovery for me is a dirty word. Right?' (SLaM FG3, male participant)* (Bird, 2014 p 648)

6.2.3 Identity

Rebuilding/redefining a positive sense of identity. many people identified that Mental health problems can dislocate or undermine their sense of identity and self-worth. One key to recovery can involve redefining or regaining a positive sense of self. For some, the process of recovery is seen as involving some transformation of identity (discovering a new 'me').

> *'So when you let go of the old person and say, "There's going to be a new one, a better one", then you'll go quicker towards recovery. That's what I discovered.' (SLaM FG2, male participant)* (Bird, 2014 p 648)

However, not all participants shared this perspective and it emerged that for some participants the goal of reclaiming their prior social identity and sense of self was important.

'Recovery for me is, 2 years ago I have family, job, every single thing. And I want to recover my previous life.' (SLaM FG2, male participant) (Bird, 2014 p 648)

Multiple dimensions of identity. Regardless of the person's aspiration regarding the relationship between their identity and their experiences of mental illness, for most people it was important that they saw themselves as more than just their diagnosis. This was linked to the idea that an individual's identity included cultural, ethnic and sexual identity. In particular, having mental health services and professionals who valued different dimensions of identity and treated you as an individual was crucial.

'She hasn't looked at me, at the colour of my skin, or my culture or background, she's just taking me as an individual.' (Gloucester FG2, female participant) (Bird, 2014 p 648)

Overcoming stigma. Part of the journey to regain a positive sense of self identified by participants was in relation to overcoming stigma and, hence, it was seen that wider society needed to be on board with recovery.

'When I heard that I had a mental health problem I ran a mile. I was not connecting with the system, so, recovery, it's not just on us, it's on the outside as well. Because once they recover and there's no longer that stigma against mental health then we might feel a bit better in ourselves.' (SLaM FG3, female participant) (Bird, 2014 p 649)

6.2.4 Meaning and purpose

Meaning and purpose included themes that ranged from finding meaning in the illness experience to rebuilding life, having meaningful social roles and included spirituality.

'For me, simply the definition of recovery is having the life you want. So it's not every day you can see your friends. It's not every day you can … but that on the days that you can do the things that you would do if you didn't have a mental illness, those are recovery days, in a nutshell.' (SLaM FG1, female participant) (Bird, 2014 p 649)

Meaningful life and social roles. Individuals stressed that the activities and occupations that made life meaningful for people without mental health problems were the same activities and occupations that made life meaningful if you had a mental health problem.

'I think psychiatrists can do worse than just to think … what's important in their daily life, service users are no different. All the things that everybody, every normal person wants, service users want exactly the same, they just need support to get it.' (SLaM FG1, male participant) (Bird, 2014 p 649)

Rebuilding of life. For some individuals having a purpose or a reason to get up each day could include volunteering, which allowed them to feel that they were giving back to the community and achieving within their day-to-day lives. This for many was part of rebuilding a meaningful life.

'I volunteer at the [service for disabled people] and I feel like I'm contributing to people. So when a week's gone by I don't think, "Oh, that's another wasted week." I think I've done something useful.' (Leicester FG1, male participant) (Bird, 2014 p 649)

Meaning of the mental illness experience. Recovery could also include understanding or finding meaning in the mental illness experience. For some this included spiritual or religious meanings and others a medical view of mental illness gave them meaning.

6.2.5 Empowerment

Empowerment emerged as central to the recovery process and was achieved in different ways, including personal responsibility, having control over life and focusing on strengths.

Personal responsibility. Empowerment can mean being involved in decision-making and having some say in their care, treatment and support, particularly where medication and hospitalisation were concerned. Personal responsibility could also involve positive risk taking, particularly in the context of care planning and goal setting –and it was helpful when this was supported by the professionals involved.

'I always used to tell the doctor if I was reducing. I would inform him or her, "I'm going to reduce my medication. You don't mind, do you?" And he'd say, "Well, we're all against it but it's up to you." But because if I had a problem I'd go back to him, "I've got a problem and I've increased it again" they got used to that and they started to trust me.' (Gloucester FG1, male participant) (Bird, 2014 p 649)

Not all participants wanted to have control over their medication and saw it as the professionals' role to deal with this.

'I would avoid self-medication. Some people are allowed to choose, to a certain degree, what dosage they take, what times they take. I would always want a professional person to say, "That is what you require for your illness." Mess with tablets, it could end up a catastrophe, couldn't it?' (Gloucester FG1, male participant) (Bird, 2014 p 649)

This suggests a more nuanced understanding of empowerment that involves taking informed choices as to which sorts of decisions people make for themselves and which they may wish to leave with professionals.

Control over life. For some people, feeling in control meant being able to get on with day-to-day life, even when symptoms were present. This included maintaining good physical and mental health, using self-management strategies, accessing self-help materials or seeking professional support as appropriate.

'I know my symptoms and I think other people around me do know when I'm not well. But, like I said, you have to protect yourself as well. You have to make sure that you keep yourself well and happy.' (Leicester FG1, male participant) (Bird, 2014 p 649)

Focusing on strengths. The final area covered in empowerment was focusing on strengths, where individuals often talked about adopting roles that were built around their personal strengths and resources.

'My staff are very encouraged about the good stuff I'm doing. It might not be a big deal to other people here, but little things, just like getting up in the morning and not staying in bed, having a tidy flat, clean and tidy flat, they're very encouraging. And my staff are focusing on good points because that helps instead of just the bad stuff.' (Gloucester FG2, female participant) (Bird, 2014 p 650)

6.3 Additional factors in recovery to consider

In addition to the 5 domains outlined in the CHIME framework, studies focused on recovery for individuals of Black and Minority Ethnic (BME) origin in the United Kingdom (UK) have reported a greater emphasis on spirituality and stigma and identified two additional themes: culturally specific facilitating factors and collectivist notions of recovery.

Bird (et al) also been identified that there are 3 emergent themes raised by consumers that could not be subsumed into the CHIME framework.

Practical support. Some participants stressed the importance of practical support to improve their material circumstances, access wider life opportunities or simply to survive on a day-to-day basis at times when they were less able to manage daily activities and tasks. While improvements in material circumstances may be seen to have a knock-on effect on other key processes, such as giving hope or empowerment, it is not easy just to subsume this within one of the already identified recovery processes.

Much of the recovery literature has tended to focus more on the relationship qualities; however participants were equally interested in practical outcomes that made their lives more liveable and the type of support they wanted from services and mental health professionals.

'My current social worker's done really nice things for me. I mean she's introduced me to a place that decorates a room of yours, maybe one room a year, and that's really improved my spirit.' (SLaM FG1, male participant) (Bird, 2014 p 650)

Issues around diagnosis and medication. Another theme that emerged from the analysis of the focus groups was a greater emphasis on medication and diagnosis than had previously been identified. As discussed above, some of this may be seen to relate to the theme of empowerment –participants either taking control over their medication or wishing to leave this responsibility with clinicians. However, some participants went beyond this; for example, highlighting issues around diagnosis and seeing misdiagnosis as potentially impeding recovery.

'I think also … if you're not diagnosed properly you're never going to recover.' (Gloucester FG1, male participant) (Bird, 2014 p 650)

Scepticism surrounding recovery. Finally, one theme that may reflect current economic trends which for many consumers has resulted in a loss of services and cuts to mental health provision was that recovery was greeted with a certain level of scepticism by focus group participants.

'I think recovery might be some sort of … I don't know, maybe this is a bit [of] paranoia coming out, but it might be some way of the system coping with under resource. So they'd rather shift people who aren't completely recovered, into the community.' (Gloucester FG1, male participant) (Bird, 2014 p 650)

This particular theme is associated with policy with in the UK that can impact on people's access to services once they have gained employment. In Australia this could be viewed as a 'cautionary tale' with consumers beginning to express concerns regarding the impending National Disability Insurance Scheme and the criteria that in order to obtain services your disability needs to be permanent.

Chapter 7: Relapse awareness and management

In taking a personal recovery approach, it remains important to attend to the clinical management or the need for specialist mental health support to assist with the experiences that bring consumers to the service. Consumers can experience times when they struggle more than others. This is often referred to as relapse and the distress associated with this can be more consistently manged if we support people in noticing any pattern of signs that might indicate an increase in distress or relapse and in consistently taking helpful and skilful action in response. These signs may be subtle and are often different from the symptoms of the disorder in a fully developed form. As the consumer starts to feel they are the expert in their own unique symptoms and signs then they may be more effective themselves in nipping possible relapses in the bud, also more willing to share with you a concern about possible relapse or recurrence of the mental health problem. This in turn will support them in regaining control and responsibility in their lives, and important factor in empowerment.

7.1 Identifying early warning signs

In this chapter we will use the examples of recurrence and relapse of Major Depressive disorder and Schizophrenia, both disorders where periods of remission and relapse are common, however the principles can be adapted to other mental health problems.

7.1.1 Relapse Warning Signs for Depression

We can begin by discussing the symptoms consumers notice when they start to become depressed. You can ask them "What were the signs you had when you were starting to become depressed?" or "Looking back, what might have been the first noticeable things about you, either for you or for others, that might have indicated you were heading for a relapse."

With your assistance, consumers can start to identify changes in the way they think, behave, feel or experience physical symptoms. It may be useful to ask the person to rate these from the earliest symptom to last and most distressful symptom before the depression stabilised again.

Resources for developing a care plan and a relapse symptom checklist appears in Appendix 7.

While every relapse experience is unique, a person's early warning signs tend to be similar each time.

7.2 Building a relapse drill or Action plan

Once with a patient we have established what to keep an eye out for, we can construct interventions that may be useful. These will be individual to the patient and their mental health problem but this grid may be useful.

Table 1: PULSAR Relapse Signature and Drill

Signs and Actions	WARNING SIGNS →		
	Early (Subtle, easy to miss)	Middle (Definite but Mild problem)	Late (Moderate and severe problems needing support and help)
Mine			
Family or carers			
My professional helpers			

WHOSE ACTION?

7.3 Advance statements

There are many ways and tools that are available to consumers to support their recovery and prevent re-admission to hospital or other forms of mental health care. The Mental Health Act 2014 makes provision for the use of Advance Statements. These can be very useful in assisting consumers to think about ongoing management of their distress and symptoms.

An Advance statement is a document that the consumer has written that identifies their wishes about future treatment. Under the Mental Health Act (s19-22) the authorised psychiatrist must have regard to "the person's views and preferences about treatment of his or her mental illness and the reasons for those views and preferences, including any recovery outcomes that the person would like to achieve"

7.4 Nominated persons

An additional support for consumers and staff in developing care and relapse plans are Nominated Persons. The role of the nominated person is to provide the patient with support and to help represent the interests of the patient. This may include

- receiving information about the consumer

- being one of the persons who must be consulted about the consumers treatment

- assisting the consumer to exercise any right that the patient has under this Act.

The Act is available for download at http://www.legislation.vic.gov.au/ and additional information and resources are outlined in Appendix 7.

7.5 Risk and recovery

Despite mental health national policies and legislation in most English speaking countries being based on recovery principles and new expectations that the 'dignity of risk' of consumers will be upheld, there is minimal guidance about how a narrow focus on the risk of violence, self harm and deterioration in health can be broadened to enable a more holistic approach[17] Shifting away from an emphasis on risk management implies new skills and ways of thinking that encourage tolerance of risk by both workers and the systems they work in[18] It also requires the commitments to a recovery orientated approach being evident and given validity in responding to perceived risks.

For example actions are considered not only in relation to whether a potential risk will be contained or prevented but also in relation to the implications of risk adverse actions for the person and their informal supporters in terms of harms to their identity, feelings of hope and empowerment.[17] As Heller[19] suggests currently an evidence based risk assessment is unlikely to focus on these issues, and it may not give priority to the person's strengths or other protective factors.

Both the Commonwealth and State governments in Australia have developed policy frameworks encouraging recovery oriented practice in mental health services. The Victorian Government (2011) in its *Framework for recovery oriented practice*[2] provides the following guidance on "balancing risk"; Firstly it defines informed risk taking as "dignity of risk" or positive risk taking. It describes informed risk taking as involving optimising informed choice and consumer-led decision making, even where this involves a degree of perceived risk. It describes the consumer-led literature on recovery as highlighting the importance of self-determination, self-responsibility and supporting people to decide the level of risk they are prepared to take with their health and wellbeing.

Therefore:

Given that a recovery approach involves promoting people's choice, agency and self-management, a degree of risk tolerance in services becomes necessary. As such, services can empower people – within a safe environment and within the parameters of duty of care – to decide the level of risk they are prepared to take as part of their recovery journey. In supporting people's recovery efforts, it is necessary for services to articulate the threshold of risk appropriate to the particular service setting. Accordingly, services should consider providing guidance, training and support to staff on how to reconcile flexibility and responsiveness to people's unique circumstances and preferences with appropriate risk management obligations. (p.3).

The national policy (Australian Health Ministers' Advisory Council, 2013)[3] states:

Therapeutic relationships are key in the management of safety. Robust, mutually respectful and trusting, diverse, active and participatory relationships between the person with mental health issues and the service provider will contribute to that person's successful management of their own safety.(Australian Health Ministers' Advisory Council, 2013.p.19)

In these policies, a safe and supportive environment is encouraged and this supports Heller's[19] conclusion that a therapeutic relationship provides the strongest potential for a shift away from coercive or otherwise paternalistic responses when fears about risk emerge. It also suggests the need to be authentic and share information such that the "parameters of duty of care" and "the threshold of risk appropriate to the particular service setting" are transparent, well understood and consistently adhered to[18] Mechanisms such as Advance Statements may assist to emphasise person centered approaches and enable consumers' greater choice and control.[20]

Sykes et all[21] suggest a reframing of the focus – from risk to "harm" and recognising that harm can include the iatrogenic impacts of coercive interventions and that this should be taken into account in recovery orientated work. They refer to the potential benefit of service users, their informal supporters and other stakeholders being involved in person centered safety planning[22,3] Good practice in focusing on recovery and supported decision making needs to start with really listening and responding to what people say they need and represents the least harmful approach for all.[18]

Chapter 8: Implementation in the PULSAR Trial

8.1 Summary of implementation strategies

In the PULSAR Trial, the intervention is the training and ongoing support and learning opportunities.

8.1.1 Personal recovery training

Personal recovery training will be provided for identified teams across Monash Health, Mind Australia and Ermha. Core knowledge and opportunities for staff and their teams to reflect on personal and professional values and ways of relating to people using the service will be covered.

The Personal Recovery training will be delivered by two trainers, at least one of whom will have lived experience. It will use a combination of training methods, including; learning new recovery knowledge and skills via face to face teaching, self-directed, independent learning, group discussions, role play, and learning by doing.

Four spaced half-day training sessions, that can be taught in two spaced full day's sessions, will be provided to each team.

The learning objectives are:

- Enhance understanding of what is meant by personal recovery

- Introduce the CHIME Conceptual Framework, stages of recovery, the recovery framework of three working practices and empirical evidence about rates of recovery

- Provide opportunity to consider and practice pro-recovery language in the team

- Identify tensions between risk and recovery and Australian issues of Community Treatment Orders and good practice principles

- Identify recovery-supporting strengths and existing good practice, skills and knowledge of staff

- Explore the impact of personal and professional values, beliefs, working practices, routines and boundaries

- Identify how the well-being of people accessing services can be supported

- Introduce coaching frameworks of GROW and REACH

- Increase knowledge and skills for working in a recovery orientated way and to actively value diversity and difference.

In both training and coaching the following objectives occur:

- Provide support staff in developing their recovery practices through a coaching model

- Discuss difficulties by identifying pragmatic and dynamic coaching responses

- Further explore the potential tensions between risk management and recovery and potential responses

- Develop the skills of staff in supporting recovery and developing recovery promoting relationships

- Note and value existing relevant expertise and experience in workers

Each training session will include materials to read or watch before the session. The training is for all members of the identified teams, and intended for all disciplines with in the team.

8.1.2 PULSAR Action Learning Sessions (PALS), Recovery coaching and reflection opportunities

The major purpose of coaching skills training is to develop a recovery-promoting relationship and for use with the working practices. The PULSAR Action Learning Sessions (PALS), and reflection opportunities will be delivered by the Consumer Educator and other staff as required from PULSAR or the agency where it is being delivered. The coaching includes the development of coaching skills and their applicability in the three working practices outlined in this manual, namely (i) understanding values, treatment and support preferences, (ii) assessing strengths, and (iii) supporting goal-striving. The reflection sessions that will be offered will include discussion of difficulties that occur and may consider issues around Community Treatment Orders (CTO's), advance statements, nominated persons, and so on.

PALS will be delivered to intervention teams over monthly sessions offered on location over a 12 month period.

This strategy comprises:

- Information and skills practice in coaching

- Monthly session developing skills in coaching as an interpersonal style as applied to the three working practices.

- Follow-up to review progress, provides further skills training, and address barriers.

Specifically, the objects of coaching training are to Introduce and develop the core coaching skills of:

- Contracting

- Exquisite listening

- Using powerful questions

- Skills to challenge and confront

- Goal setting

- Feedback

Providing participants in the participating setting with increased understanding of the importance of:

- Recognising the difference between coaching, mentoring and directing.

- Focusing and holding attention on priorities.

- Using the REACH© coaching model to have effective coaching style conversations, hold to account and creatively achieve agreed outcomes.

Encouraging participants to:

- Integrate coaching skills with occupational competencies to support effective skills-transfer in the workplace.

- Integrate coaching skills into their repertoire of work skill so as to work effectively with the PULSAR intervention's three working practices.

8.1.3 Team manager/leader reflection groups

A quarterly reflection group for managers and team leaders will be offered to provide support, as they attempt to create the culture in which the intervention can be implemented whilst also meeting other demands on the team. This strategy involves four one-hour groups. The group will voluntarily involve team managers and leaders from all participating agencies. Meetings will be organised and facilitated by the trainers (one from a professional perspective and one from a lived experience perspective). The aim of the group is to help team managers and leaders to lead implementation by reflecting and learning from others, and by supporting each other. This will involve sharing good practice, supporting the use of coaching as an interpersonal style within the team, and problem-solving barriers to implementing the working practices. The session will involve:

- Identifying anticipated blocks and enablers, organise dates for remaining meetings

- Reviewing progress, share experiences, solve problems.

8.1.4 Supervision reflection

Supervision, where available and used, may be used as an opportunity to prompt personal reflection on practice and progress in developing pro-recovery practice. This strategy involves the use of the Supervision Reflection Form (shown in Appendix 6) at each supervision. It can be used either for personal reflection or – where possible – for discussion in the supervision meeting.

Figure 2: Timetable for implementation

Figure 2 shows how the intervention will be implemented over the 12 months.
It will then be repeated for a second group.

Implementation strategy	Timeframe – Months											
	1	2	3	4	5	6	7	8	9	10	11	12
1. Personal recovery training – 2 days equivalent in first two months	🟥	🟥										
2. Monthly coaching and working practice training and reflection opportunities			🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥	🟥
3. Team manager reflection groups			🟥			🟥			🟥			🟥
4. Supervision reflection – as per normal practice.			🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦	🟦

🟥 Provided to the agencies

🟦 Self-organised by the team members

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Appendix 1 – Values, Treatment and Support Preferences (VTSP) interview guide

Name of person using the service:

Name of worker:

For each area ask: What would be helpful for me to know? What is important to you?

Cultural identity including race, culture and ethnicity

How would you describe your ethnicity? Prompts: language, parents background.
Tell me a little bit about yourself and your culture. Prompt preferred diet, social life, cultural behaviours, beliefs, involvement with cultural group

---

Religion/spirituality

Is spirituality or religion important to you? Prompts: how, in what ways?
What is your spiritual/religious background?
How do your beliefs affect your feelings towards your mental health experiences?

Gender

Does being a <man/woman> affect the way you would like to be treated by mental health services?
Prompts: how? e.g. gender of staff, type of treatment or support?

Sexuality

Is there anything you would like to discuss about your sexuality or that you feel is important to you?
Prompts: does this impact on how services treat you?

Social roles including the family, peers and community

Tell me about your community, What role do family, friends and peers play in your life?
What social roles do you have?
Prompts: role in the community, social networks, caregiver, parent, peers with and without similar experiences

Meaning of 'mental illness' experience

People understand 'mental health experiences in different ways e.g. an illness, an emotional crisis, as physical illness or as a spiritual experience etc. Could you tell me what you call this experience? What do you think has caused your experience?

Previous experiences of services

What has been helpful or unhelpful about your experience of using mental health services?

Stigma and discrimination

Do people treat you differently because of mental health issues?
Have you experienced other forms of stigma or discrimination (such as racism or sexism)?
Prompts: how has this affected you? Does it have an impact on the service you receive?

Other important parts of your identity

Anything else you would like to add? e.g. creative, dancer, runner, student, electrician, teacher etc.

TREATMENT PREFERENCES

In what ways do the above influence your treatment and support preferences, For each area above, what support if any would you like? How would you like workers to work with you?

Appendix 2 – Additional resources for consumers experiences

Print resources

Brown, Wendy (2008) *Narratives of Mental Health Recovery.* Social Alternatives Vol. 27 No. 4 pp 42-48.

Mancini, Micheal A and Rogers, Rebecca (2007) *Narratives of Recovery from Serious Psychiatric Disabilities: A Critical Discourse Analysis.* Critical Approaches to Discourse Analysis across Disciplines 1 (2): 35-50 Electronic resources.

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Jerry Tew, John Larsen, Sarah Hamilton, Jill Manthorpe, Naomi Clewett, Vanessa Pinfold, and Paulina Szymczynska. (2015) *'And the Stuff that I'm Able to Achieve Now Is Really Amazing': The Potential of Personal Budgets as a Mechanism for Supporting Recovery in Mental Health* British Journal of Social Work (2015) 45, Supplement 1, pp 79–97.

Electronic resources

Personal narratives

- www.scottishrecovery.net – Details of the narrative project and example narratives, alongside extensive information about ways to promotes recovery.

- Personal stories by people with a mental illness, their families and friends.
  http://www.mentalhealth.wa.gov.au/mental_illness_and_health/stories.aspx

- https://www.beyondblue.org.au/connect-with-others/personal-stories

- http://www.mentalhealth.com/story/p52.html

- https://www.headsup.org.au/training-and-resources/personal-experience-videos

- http://www.mindfreedom.org/personal-stories/personal-stories

- http://www.abc.net.au/news/2015-09-30/rural-youth-talk-mental-health/6798262

- http://www.mentalhealth.wa.gov.au/mental_illness_and_health/stories.aspx

- http://theicarusproject.net/

Life maps

- www.docstoc.com/docs/947552/FREE-Mind-Map-Templates – mind mapping templates

- www.mindmapinspiration.co.uk – examples of completed mind maps.

Appendix 3 – Strengths Worksheet

Name of person using the service:

Name of worker:

Currently What's going on today? What's available now?	**Desires and aspirations** What do I want?	**Personal and social resources** What have I used in the past?
Daily living situation		
e.g. Where are you living now? What things do you like about your current living situation? How do you get around?	*e.g. Do you want to remain where you are, would you like to move? If you could change anything about your living situation what would it be?*	*e.g. Where have you lived in the past? What was your favourite living situation? Why?*
Financial		
e.g. What are your current sources of income, and how much money do you have each month to work with?	*e.g. What do you want to happen regarding your financial situation?*	*e.g. What was the most satisfying time in your life regarding your financial circumstances?*
Occupational e.g. educational, vocational, leisure		
e.g. What kind of things do you do that make you happy, and give you a sense of personal satisfaction?	*e.g. What kind of activities or things would you like to do or be involved in?*	*e.g. What are the most satisfying activities that you have ever been involved in?*

Currently What's going on today? What's available now?	Desires and aspirations What do I want?	Personal and social resources What have I used in the past?
Social Supports		
e.g. Who do you spend your time with? Who do you feel close to? What do you like to do?	e.g. Is there anything you would like to be different in your social life? Are there any areas you would like to have more support?	e.g. Have you ever belonged to any groups, clubs or organisations? What did you enjoy about them?
Health		
e.g. What kinds of things do you do to take care of your health? Is being in good health important to you? Why or why not?	e.g. Are there things you would like to work in this area? Is there anything you would like to learn more about to improve or change your health	e.g. How do you know when you're not doing too well? What is most helpful during these times in the past?
Spiritual and cultural		
e.g. What meaning, if any, does spirituality play in your life? Are there any strong beliefs held by your family? What do you think of this?	e.g. Would you like to feel more connected to your spiritual beliefs?	e.g. What do you value most in life, have you always felt that way? What gives you strength to carry on in times of difficulty?

Anything else you would like to add

Appendix 4 – Strengths Worksheet checklist

This checklist gives some example prompt questions for areas to discuss in completing the Strengths Worksheet. The checklist has been adapted,[12] and is not a definitive list of areas. Individuals have unique talents, interests and abilities which may not be covered by the below.

Daily Living

Current situation

- [ ] Where the person lives and for how long. Does the person live with anyone else?

- [ ] Advantages of the person's living arrangements e.g. quiet neighbourhood, close to town, Transport options

- [ ] Pets or animals

- [ ] Personal possessions available to the person (e.g. internet, exercise bike etc.) – this can be used to identify what is wanted

- [ ] Areas of the home or neighbourhood that the individual is proud of or enjoys

- [ ] Daily living tasks that the person enjoys doing or is good at (e.g. cooking, shopping)

Desires and aspirations

- [ ] Where would the person like to live? Do they like living alone/with others?

- [ ] Desired changes to the living situation, what is their Ideal living situation

- [ ] Anything that would make the individual's living situation easier (e.g. appliances, better transport options etc.)?

- [ ] Most important aspect of the living situation (e.g. being near friends, good transport links, having a pet)

Personal and social resources

- [ ] Past living arrangements, What did the person like about past living arrangements?

- [ ] Favourite accommodation and living situation

- [ ] Anything from past living situations which the person would like to have now

Financial

Current situation

- [ ] Sources of income

- [ ] Bank account, Savings account etc?

- [ ] Does the individual budget and manage their money, how? How do they pay the bills? Is there Spending money left over?

Dreams and aspirations

- [ ] Would the individual like to change their financial situation?

- [ ] What is important about their financial situation (e.g. extra money to be able to eat out, go on holiday etc.)

- [ ] Are there additional benefits the person may be entitled to

Personal and social resources

- [ ] Past income sources, (e.g. did they work in the past, get additional benefits)

- [ ] Resources in the past that they are not using now (e.g. savings account, accountant/advisor)

Occupational e.g. work, leisure, education

Current situation

- [ ] What does the person do for fun, hobbies, How does the person relax and enjoy themselves

- [ ] Different types of activities e.g. paid employment, volunteer work, educational activities, helping others, job searching, involvement with services, care giving etc.

- [ ] Education (achievements, likes, dislikes)

- [ ] What does the individual like about their activities (educational, vocational and leisure)

- [ ] What is important to the person about their current activities

- [ ] Interests, skills and abilities related to their activities

- [ ] Weekend activities (do they go out at the weekend)

- [ ] When does the person get bored and what do they do when they are bored?

Dreams and aspirations

- [ ] Does the person want to work, study, do more/different activities?

- [ ] If the person could do anything what would that be (career, leisure, educational)

- [ ] Is the person satisfied with what they are doing?

- [ ] What enjoyable things would the person like to be doing?

- [ ] Have they ever wanted to try something?

Personal and social resources

- [ ] Past work, leisure and education experience

- [ ] What type of activities have they enjoyed in the past, with whom

- [ ] What kind of services (voluntary and involuntary) have they found helpful?

Social Supports

Current situation

- [ ] Who do they spend time with? Friends, family, who are they close to? Pets

- [ ] Organisation, clubs or groups they participate in

- [ ] What things does the individual do with others?

- [ ] Types of social support available e.g. family, friends, significant others, mental health workers, religious leaders and members of religious groups, sport clubs, self-help organisations etc. How do people support the individual?

- [ ] Likes and dislikes about being with others

- [ ] What does the person do when alone, do they like being alone?

- [ ] Where, outside the home does the person feel at ease?

Desires and aspirations

- [ ] Any changes the individual would make to their social life

- [ ] Areas of life the individual would like more support in, what type of support?

- [ ] Groups, organisations or clubs they would like to belong to?

Personal and social resources

- [ ] Important people in the individual's life (family, friends etc.)

- [ ] Places that the individual use to enjoy going to

- [ ] Groups or clubs the individual was a part of

Health

Current situation

☐ Mental health e.g. people individual currently sees, medication, treatments

☐ How does the person manage stress

☐ How does the individual cope with the illness

☐ Physical health e.g. doctors, dentist, any medication

☐ Diet and eating habits

☐ Smoking

☐ Exercise

Dreams and aspirations

☐ Areas the individual would like to work on

☐ What is important to the individual, anything they would like to change?

Personal and social resources

☐ Resources used in the past to manage physical and mental wellbeing

☐ What resources were helpful? Why?

Spirituality and Culture

In this case, spirituality doesn't just refer to an organised religion, instead it relates to any beliefs or practices that give a person's life meaning and purpose, e.g. by generating hope, comfort or connections. Individuals can belong to more than one cultural group, so the conversation should include the different cultures the person identifies with, identifying how strongly they identify with each.

Current situation

☐ Is there anything which brings comfort, meaning and purpose to the individual's life?

☐ What gives the person strength in times of difficulty

☐ Individual's beliefs, what does the individual have faith in?

☐ Any rituals the person engages with, Important occasions for the individual

☐ Family roles and practices, e.g. mother as main care giver, extended family etc.

☐ Languages spoken

☐ Certain types of food enjoyed by the individual

Dreams and aspirations

☐ Any changes the individual would make, e.g. go to church more often, visit parents' home country

☐ Connections with others from the same cultural groups

Personal and social resources

☐ Past spiritual or religious beliefs?

☐ How has a person's spirituality or cultural practices/beliefs supported them in the past?

☐ Celebrations, rituals that the person use to observe or celebrate

Appendix 5 – Example of a clinical or service record information record example and templates

Values, treatment and support preferences

This appendix is an example of how you might complete a medical record following the PULSAR training. After discussing the person's values, treatment and support preferences, record these in your record. Consider using the categories Cultural identity including race, culture and ethnicity; Religion/spirituality; Gender; Sexuality; Social roles including the family, peers and community; Meaning of 'mental illness' experience; Previous experiences of services; Stigma and discrimination; Other important parts of your identity; Treatment and support preferences.

> May identifies herself as a Vietnamese Australian woman. Although both her parents were born in Vietnam, May was born in Australia and has not been to Vietnam, so identifies herself as Australian. May has a diagnosis of schizophrenia, currently managed with medication. However May believes her experiences are an emotional response to a very difficult time. In the past she has experienced racism, which she feels has contributed to her current emotional difficulties. May identified herself as a Christian and would like help to reconnect with her religion and would like to re-attend a local church or Christian group. May attends a range of services and likes to have different options, and control over the places she attends, which include meeting people and having friends from a range of backgrounds. She describes herself as a creative and social person and would like the opportunity to express this within services.

Summary of strengths

After discussing the person's individual strengths and community resources, record these here. Consider using the categories Daily living situation; Financial; Occupational (e.g. educational, vocational, leisure); Social supports; Health (e.g. mental, physical); Spiritual and cultural; and other.

> **Daily living situation**
> May lives independently in a one-bed flat.
>
> **Financial**
> May manages her finances independently and budgets responsibly. She hopes to save enough money for a holiday next year.
>
> **Occupational e.g. educational, vocational, leisure**
> May has enrolled at college and attends a part-time course. She has also recently attended after-college activities.
>
> **Social supports**
> May has made new friends at college and is building her confidence in meeting new people.
>
> **Health e.g. mental health/physical health**
> May self-manages all health needs. She has learnt to ask for support if she feels she needs it.
>
> **Spiritual and cultural**
> May has attended a church group in the past where she was a valued member.

Personally valued goals

After discussing the person's valued goals, record these here. Number each goal separately.

> **Goal 1:** May would like to continue to build her confidence in meeting new people at college
>
> **Goal 2:** May would like to use other strategies besides medication to manage her illness
>
> **Goal 3:** May would like to attend a local church or Christian group.

Appendix 6 – Personal and/or Supervision Reflection Form

Please use this form as a prompt to reflection as part of your personal reflection practice or before each supervision meeting you have. Where possible discuss it in supervision with your supervisor.

Think about the people you provide services for.

---

1. How much do you know their values, treatment and support preferences strengths and goals?

Be concrete – think about specific people:
- *When do you ask, and when do you not ask, about these things?*
- *Think about the people for whom you do know these things, and those you don't. How do these two groups of people differ? You might consider characteristics like gender, ethnicity, working alliance, or the time you have known the person. Does this highlight anything for how you work with people?*

---

2. How much is your work with people orientated around supporting their goals and using approaches of their choosing?

Think about the care plans you're working with:
- *How many of the goals came from the person themselves?*
- *Is your work focussed on approach goals (making positive things happen) or avoidance goals (avoiding negative things from happening)?*
- *Are there ways in which you could support the person to do more for themselves?*
- *How do the person's values, treatment preferences inform their care plan?*
- *How is the care plan amplifying their strengths?*

Appendix 7 – Care Plans, an Example of a Relapse Symptoms Checklist and other resources.

Resources for Care Plans

There are many different types of care plans available. Mental health services may have a template that is supported by their systems to use. In addition you may find the following websites useful when working with consumers to develop a care plan or relapse prevention plan.

- mentalhealthrecovery.com

- www.power2u.org

- mvbcn.org/home/mv1/smartlist_144/personal_actioncrisis_prevention_plan.html

- cci.health.wa.gov.au/docs/KYB-3-Self%20Monitoring.pdf

- mhpod.gov.au/assets/sample_topics/combined/Relapse_Prevention

- anxietyuk.org.uk/docs/Relapse%20prevention%20kit.pdf

Resources for Advance statements

The Mind Recovery College has information about advance statements:

- https://www.mindaustralia.org.au/resources/about-mental-ill-health/advance-statement.html

The Department of Health Provides information about advance statements in the Mental Health Hand Book. The handbook website has links to a number of useful documents, including a sample form.

- https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/recovery-and-supported-decision-making/advance-statements

Resources for Nominated Persons

The Department of Health Provides information about nominated persons in the Mental Health Hand Book.

- https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014-handbook/recovery-and-supported-decision-making/nominated-persons

Relapse Warning Signs for Depression

Early symptoms = 1   Later symptoms = 5

Symptom	Rating	Symptom	Rating
Feeling sad or gloomy		Poor concentration	
Increased moodiness, irritability or impatience		Destructive risk taking	
More aches and pains, feeling physically ill		Increased or more urgent suicidal thoughts	
Increased skin problems/eczema		Ideas that you can't cope	
Lack of appetite OR overeating		Increased physical feelings such as trembling, nausea,	
Decrease in activities/withdrawal from contact		Increased feelings of dread	
Decreasing/stopping exercising		Crying/teariness	
Difficulty in getting going		Unable to concentrate/confusion	
Physical tiredness/fatigue		Poor judgement	
Mental tiredness/fatigue		Insomnia	
Emotional tiredness or 'deadness'		. . . .	
Unable to experience pleasure		. . . .	
Increased blaming of yourself		. . . .	
Lower self-confidence/more self critical		. . . .	
Increased use of drugs/alcohol		. . . .	
Seeing oneself in more negative light		. . . .	
Listlessness/procrastination		. . . .	
Negative attitude/insecurity		. . . .	
Disturbed sleep/difficulty getting up		. . . .	

Note: Although these are common examples, your client may experience only some of these, or may experience others that are not on the list.

Relapse Warning Signs for Schizophrenia

Some of the common early signs of relapse may include:

Early sign	Present	Action
Restless or unsettled sleep		
Feelings of tension or nervousness		
Having a hard time concentrating		
Not wanting to spend time with others; staying isolated		
Feeling irritable or having a short temper		
Having trouble taking care of routine things		
Feeling a lack of energy		
Feeling sad or depressed		
Feeling confused		
A change in appetite		

Relapse Warning Signs for Bipolar Disorder

This set of symptoms may be useful in building relapse signatures for bipolar disorder

Early sign	Present	Action
Disturbed (or lack of) sleep; feeling extremely excited		
Talking quickly and talking more than usual		
Making big plans without thinking them through		
Acting reckless		
Feeling very tired		
Feeling very depressed		

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Associate Professor Brendan Murphy	Pine Lodge Clinic
Ms Vrinda Edan	Consumer Academic, Monash University
Ms Christine Thornton	Eastern Region Mental Health Association (ERMHA Inc.)
Dr Margaret Grigg	Mind Australia
Dr Lisa Brophy	The Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne, and Mind Australia
Professor Grant Russell	School of Primary Health Care, Faculty of MN&HS, Monash University
Associate Professor Harry Minas	Global and Cultural Mental Health Unit, Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne
Dr Ritsuko Kakuma	Global and Cultural Mental Health Unit, Centre for Mental Health, Melbourne School of Population and Global Health, The University of Melbourne
Professor Brett Inder	Department of Econometrics & Business Statistics Monash University
Associate Professor Penelope Weller	RMIT University, Melbourne
Associate Professor Elisabeth Wilson-Evered	Professor of Business, College of Business, Victoria University
Professor Ellie Fossey	Department of Occupational Therapy, School of Primary Health Care, Monash University & Adjunct Professor, Discipline of Occupational Therapy, School of Allied Health, La Trobe University
Mr John Julian	Southern Synergy, School of Psychiatry, Monash University
Dr Joanne Brooker	Cabrini Hospital
Professor David Clarke	Community, Access & Partnerships, Mental Health Program Monash Health, Monash University
Professor Danielle Mazza	Department of General Practice, School of Primary Health Care, Monash University
Dr Joanne Enticott	Deputy Director and Coordinator of Health Services Research Southern Synergy
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Dr Mehmet Ozmen	Research Fellow, Monash University
Dr Fran Shawyer	Research Fellow, Monash University
Dr Siva Vasi	Research Fellow, Monash University

Management and advisory structure

The PULSAR project has developed a module based approach to undertaking the work, supported by an advisory structure to manage and guide its development.

Module structure

PULSAR project is being managed through a project steering group (Chair: Professor Graham Meadows), and Project Management Office managed by Professor Meadows. Each of the 4 modules has a task group and chairperson.

The module task groups and chairs are:

- Adaptation Module (Chair: Christine Thornton)
- Implementation Module (Chair: Penny Weller)
- Research module (Chair: Lisa Brophy)
- Dissemination module (Chair: Vrinda Edan)

Lived Experience Advisory Panel

A consumer and Family/Carer advisory group was formed and identified as LEAP – Lived Experience Advisory Panel. The members of this panel include:

Vrinda Edan	Consumer Academic, Monash University
Joanne Sheedy	Senior Consumer Consultant, Monash Health Mental Health Program
Katrina Clarke	Senior Family/Carer Consultant, Monash Health Mental Health Program
Peter Mackenzie	Carer Academic, Latrobe University
Dean Barton Smith	CEO, Victorian Mental Illness Awareness Council
Patricia Rogerson	Family/Carer Advisor, Tandem
Wendy Muller	Consumer Advisor, (from April 2015)
Tamara Stillwell	Consumer Advisor, Ermha (from Sept 2015)
Salome Argyropoulos	Consumer Advisor, SEMPHN
Rose Coulter	Family/Carer Advisor, SEMPHN
Professor Ellie Fossey	Department of Occupational Therapy, School of Primary Health Care, Monash University & Adjunct Professor, Discipline of Occupational Therapy, School of Allied Health, La Trobe University

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Help, hope and purpose

MonashHealth

Refocus on
Recovery

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