rethink

REFOCUS

Promoting recovery in community mental health services

Rethink recovery series: volume 4

About Rethink

Rethink, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life. We provide hope and empowerment through effective services and support to all those who need us, and campaign for change through greater awareness and understanding**.**

About REFOCUS

REFOCUS is a 5-year programme of research funded by the National Institute of Health Research (Ref RP-PG-0707-10040), which aims to support the development of a recovery orientation in community mental health teams. Part of the REFOCUS programme is the REFOCUS Trial (ISRCTN02507940) which will test the effectiveness of the REFOCUS intervention within community mental health teams. The intervention in the trial lasts for 18 months and is described in this manual.

Foreword

Rethink believes that people with mental illness should be encouraged to achieve personal goals in all areas of life. We have worked for many years to make our 300 services more recovery-centred and want to use our experience to help other mental health services to become more person and recovery-oriented.

The REFOCUS study involves a trial of a new approach to supporting mental health services to become more recovery-focused. The intervention used a mix of strategies to achieve this goal, including information sharing, personal recovery training and team reflection. This report will describe the different strategies, which we hope will be of use to professionals across the mental health world who are thinking about how to embed recovery in practice. Rethink is involved in the intervention by providing the personal recovery training, co-delivered by people with personal experience of mental illness.

Rethink is committed to improving the lives of over a million people in the UK experiencing mental illnesses such as schizophrenia, bipolar disorder and severe depression. You can read more about recovery ideas in the three previous volumes of the Rethink Recovery Series: *100 ways to support recovery* – providing an overview of existing knowledge about 'personal recovery' and offering concrete suggestions for mental health professionals; *Getting back into the world* – detailing findings from a study where seven service user researchers interviewed others about experiences of recovery; and *Recovery insights* – using the same study to provide recommendations on how to support recovery for people experiencing mental health problems, friends and family and mental health professionals.

This fourth volume in the series is authored by the REFOCUS study team, led by Dr Mike Slade, who is a consultant clinical psychologist with South London and Maudsley NHS Foundation Trust and a Reader within the Health Service and Population Research Department at the Institute of Psychiatry, King's College London. Rethink is proud to be associated with critically examining the meaning and value of recovery, and seeking to establish a robust evidence-base.

If you want to explore ideas about how Rethink could support you or your team to work in better ways with people with mental illness, please get in touch.

Paul Jenkins
Chief Executive, Rethink
April 2011

Executive summary

This is the REFOCUS Manual, which describes an intervention aimed at increasing the focus of community adult mental health teams on supporting personal recovery. The intervention is in addition to standard care and has two components: Recovery-promoting relationships and Working practices.

Recovery-promoting relationships

The working relationship between staff and people who use the service 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

- Teams planning and carrying out a partnership project with people who use the service

- Raising the expectations held by people who use the service that their values, strengths and goals will be prioritised

Working practice 1
Understanding values and treatment preferences

To ensure that care planning is based around the person's values and treatment preferences, the intervention involves:

- Individuals who use the service discussing their values and treatment preferences with staff

- Recording these values and treatment preferences on the clinical information system

Working practice 2
Assessing strengths

To ensure care planning is focussed on amplifying a person's strengths and ability to access community supports, the intervention involves:

- Individuals who use services identifying their strengths with staff using the strengths assessment worksheet

- Recording these strengths on the clinical 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:

- People who use the service identifying their personally valued goals with staff

- Recording personally valued goals on the clinical information system

- Staff supporting people who use the service in striving towards their goals

Implementation strategies

Six implementation strategies will be used:

- Information sharing

- Personal recovery training

- Coaching and working practice training

- Team manager / leader reflection groups

- Team reflection sessions

- Individual supervision reflection

Chapter 1: Overview

This REFOCUS manual describes a pro-recovery intervention and how it can be implemented by staff working in community adult mental health teams. It is written to be used in the REFOCUS Trial, so some aspects (such as the intervention lasting 18 months, the amount funded in the Partnership Project, and the implementation approach described in Chapter 6) may be modified by other services using the manual.

1.1 Purpose of the intervention

The primary aim of the intervention is to support the personal recovery of people who use services. This will involve striving towards their 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 preferences.

1.2 The intervention

The intervention is provided to teams, and is in addition to standard care. The intervention has been designed to impact in two ways: *how* staff and teams work with people using mental health services, and on *what* staff and people using the service discuss and actually do. We call these 'recovery-promoting relationships' and 'working practices' respectively. So the intervention has two components:

A. Recovery-promoting relationships

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

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

- Partnership relationships recognise the professional expertise of staff and the expertise from lived experience of people using the service. Teams will undertake a project to develop and practise partnership working, e.g. through staff and people using the service doing or learning something jointly.

B. Pro-recovery working practices

- Understanding the person's values and treatment preferences underpin an individualised approach to care planning. Workers will be trained in understanding values and in 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 be trained in assessing strengths.

- Identifying personally valued goals, developing intermediate steps, and striving towards these goals contributes to recovery. Workers will be trained to use existing care 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 community mental health teams already have many of the skills in supporting personal recovery which are outlined in this manual. The intervention has been designed to allow workers to recognise and build on these existing skills and expertise. The intervention deliberately maps onto existing care planning processes and reinforces those parts of current practice which best support recovery. The contribution of staff who already have expertise in these areas is to support others in developing pro-recovery skills, by modelling best practice and supporting implementation.

Relationships are at the heart of the intervention. Recovery-promoting relationships involve staff and people using the service working together as partners. Within this relationship, staff use their clinical 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 staff and people using the service 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 aspects, which underpin the practice 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

- Partnership project

- 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 and treatment 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. 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 supports and positive connections in their life. Identified strengths might include any skills or knowledge gained through formal education, training or work experience, 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, which identifies strengths as well as deficits. Assessing strengths is described in more detail in Chapter 4.

Working practice 3: Supporting goal-striving

This working practice maps onto the clinical process of care 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 REFOCUS Model

The intervention is based on the REFOCUS Model, 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 person using the service, and the beneficial outcomes.

The REFOCUS Model is shown in Figure 1.

Figure 1: The REFOCUS Model

The implementation approach used in the REFOCUS Trial is outlined in Chapter 6.

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

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 team manager / leader:

• participation in the team manager reflection group

• ensuring the information sheet is given to everyone on the caseload

For the whole team:

• participation in the personal recovery training

• participation in coaching training

• participation in the team reflection sessions

• planning and carrying out a partnership project

For individual workers in the team:

• using the supervision reflection form at each supervision

2.3 Values held by the worker

Values underpin all behaviours by clinicians. 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 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.

Three proposed values for recovery-orientated mental health services are shown in Box 1 [2;3]. 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 people with mental illness 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 seem, to the 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 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 do not have capacity.

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: Recovery-supporting values

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 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 professionals 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 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 professionals 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 people with a mental illness do experience personal recovery

- That recovery can take place within, partly outside or wholly outside the mental health service

- That there are many ways in which mental health services and workers can support recovery

- That stigma can be a barrier to recovery, so

  – language matters

  – beliefs that people with mental illness are fundamentally different from other people are a hindrance to supporting recovery

  – it is more helpful to emphasise the ways in which people with mental illness are similar to everyone else in society

  – other types of stigma that people who use mental health services 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 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 trial teams. For more information please see *100 Ways to Support Recovery* (rethink.org/100ways).

2.6 Coaching

Coaching is a specific interpersonal style which supports recovery[4;5]. 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 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 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 clinical frontline 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 and treatment preferences, (ii) assessing strengths, and (iii) supporting goal-striving (SLaM Partners 2010).

REACH© – The Coaching for Recovery approach and this 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 (SLaM Partners 2010).

2.7 Partnership project

Working in partnership is central to recovery orientated practice. This will involve teams developing, and experimenting with, ways of relating as partners to the people who use the service. The aim is to support people over time to have more responsibility for their own lives, and to break down any barriers which might exist caused by "them" and "us" thinking.

Part of the intervention is to conduct a partnership project for increasing partnership working (e.g. through staff and people using the service doing or learning something jointly) or making strengths and achievements more visible. The project is identified by the team, and examples may include:

- Do something jointly to help the community, e.g. a conservation or renovation project

- Set up a joint staff – individuals who use services steering group to support pro-recovery changes within the team

- Creating pathways for people using the service to move from taking part in a social group to running the group

- A user-led audit or training project

- Running a recovery group jointly facilitated by a staff member and a person using the service

- Undertaking a survey of talents of staff and people using the service, and then jointly organising a talent show

Teams taking part in the intervention arm of the REFOCUS Trial are invited to bid for up to £500 to cover the cost of undertaking a partnership project (e.g. venue hire, equipment, expenses). The partnership project proposal form is shown in Appendix 2.

Proposal forms will be assessed against the following criteria:

1. Is this a service user partnership project?
2. Is this consistent with recovery values?
3. Are at least one person who uses services and one staff member involved in project planning team?
4. Has the cost been justified?

2.8 Raising expectations held by people using the service

People who use services can be active agents in shaping the content of clinical interactions. An information sheet about the study (shown in Appendix 1) will be sent out to all people on the team's caseload. This will give an explanation of what the study includes and how people using the service can be actively involved. Staff are also encouraged to talk to people who use the service about the REFOCUS 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 practices 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 and treatment preferences

3.1 Understanding values contributes to recovery

Mental health workers who support recovery orientate their actions around the values in life and treatment 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 planning is consistent as far as possible with the individual's values. The aim of this working practice is to be able to record information about values and treatment preferences on the clinical information system.

3.2 What the intervention involves

Workers are asked to do two things:

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

2. Record an agreed summary of these values and treatment preferences on the clinical 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 Black and Minority Ethnic (BME) communities or gay, lesbian, bisexual and transgender individuals. In terms of treatment, having values and treatment preferences discussed, listened to and acted on all contribute to recovery.

An understanding of a person's values and treatment 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 stigma, discrimination, racism and

previous relationships with services. This process will take time and involve many conversations so trust can be built and boundaries changed to allow the discussion of these topics to take place. As people's values and treatment 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 came to be where they are in their life?

- Understanding values – what matters to the person?

- Treatment 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 to support 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

Individuals (both people using the service 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 and Treatment Preferences section of the clinical information system. An example of a completed Values and Treatment Preferences section is shown in Appendix 8.

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 and Treatment Preferences (VTP) interview shown in Appendix 3. Questions in the VTP have been modified from other sources[6;7] and give a framework for conversations about areas which have been identified as important for people in their recovery journey. The VTP – like recovery-orientated care-planning – starts with personal values and then considers treatment 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"*.

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 VPT 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. 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 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 websites listed in Appendix 4.

Common life maps (modified from elsewhere[8]) 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. 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 may 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).

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 information system

4.3 Undertaking a strengths assessment

A good assessment (adapted from elsewhere[9]) 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

- **Updated** – clear when last updated and sufficiently current to be useable

Assessing strengths involves (adapted from elsewhere[10]):

- 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 is a tool to help workers to identify and use the strengths, resources, talents and abilities of the person (shown in Appendix 5). 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 with example questions and prompts for each domain (shown in Appendix 6). To help you assess strengths an additional staff exercise is included in Appendix 7.

The agreed summary is recorded in the Strengths section of the clinical information system. An example of a completed Strengths section is included in Appendix 8.

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 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[11] 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.

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 and treatment 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 and treatment 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, Measurable, 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 and treatment 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 information system, and implemented. An example of a personally valued goals clinical information system entry is shown in Appendix 8.

Chapter 6: Implementation in the REFOCUS Trial

6.1 Summary of implementation strategies

There are many ways in which the intervention could be provided. In the REFOCUS Trial, six strategies are used to implement the intervention. These are:

1. Information sharing

2. Personal recovery training

3. Coaching and working practice training

4. Team manager / leader reflection groups

5. Team reflection sessions

6. Supervision reflection

We now describe these implementation strategies, including what they involve and when during the 18-month trial they are undertaken.

Month	Implementation Strategy 1: Information sharing
	Opportunities will be created for people using the service and staff to relate to each other as partners who both bring expertise to the relationship. For some this shift in working together will be unfamiliar, therefore people need to be supported to develop these new relationships. This strategy comprises:
1	Team information session: An information session will be held with all members of the team. The session will be led by two trainers, one speaking from a professional perspective and one from a lived experience perspective to service user/carer session. The session will give information about the REFOCUS Trial.
1	Service user and carer information session: An information session for people using the service and their carers will be held. People using the service are also welcome to invite members of staff to attend. These will give information about recovery and the REFOCUS Trial.
1	Team managers will organise for each person using the service to receive a copy of the REFOCUS Information Sheet shown in the Appendix 1.

Month	Implementation Strategy 2: Personal recovery training
1-2, 5	Personal recovery training will be provided for the whole team. Core knowledge and opportunities for the team 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 Rethink 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. It will be delivered to intervention teams, within 3 half-day sessions, spaced 2-4 weeks and 3 months apart, at the start of the intervention. Three half-day training sessions will be provided to the team. The learning objectives are: • To understand what is meant by personal recovery, including its definition, the REFOCUS Conceptual Framework, stages of recovery, what recovery means in practice, the Recovery Practice Framework and empirical evidence about rates of recovery • To explore the potential tensions between risk management and recovery • To create a shared team understanding of personal recovery, through exposure to recovery narratives and local practice (by considering what it means for the team) • To think about the role of staff in supporting recovery and developing recovery promoting relationships • To identify recovery-supporting strengths and existing good practice, skills and knowledge within the team • To increase staff self-awareness about the impact of their own, personal and professional values, beliefs, working practices, routines and boundaries • To identify parallels between how staff support their own well-being and how the well-being of people using the service can be supported • To think through the implications of a recovery orientation on team attitude and working practices, including referral and assessment processes, care planning, and approaches to discharge • To increase pro-recovery language in the team by considering what gets talked about and how • To increase knowledge, skills and motivation to work in a recovery orientated way and to actively value diversity and difference. • To plan the Partnership Project between staff and people using the service Each training session will include materials to read or watch before the session. The training is for all members of the team, and intended for the whole multidisciplinary team.

Month	Implementation Strategy 3: Recovery coaching and working practice training
	The Recovery Coaching Skills training will be delivered by one trainer from 'SLaM Partners' which is a consultancy and coaching service for South London and Maudsley NHS Foundation Trust. All coaches who deliver the Recovery Coaching Skills training are trained and skilled in coaching methods. The coaching will be provided to teams and involves tailoring an existing coaching training course so it covers the three working practices outlined in this manual, namely (i) understanding values and treatment preferences, (ii) assessing strengths, and (iii) supporting goal-striving. The Recovery Coaching Skills training will be delivered to intervention teams over 1 full day and 2 half-day sessions, spaced one month apart, at the start of the intervention.
1	**This strategy comprises:** Session 1: Information and skills practice in coaching One-day training session developing skills in coaching as an interpersonal style as applied to the three working practices.
2	Half-day follow-up session to review progress, provide further skills training, and address the challenges.
3	Half-day follow-up session to review progress, provide further skills training, and address the challenges. Follow-up phone support from the consultancy and coaching service will be available to intervention teams.

Month	Implementation Strategy 4: Team manager / leader reflection groups
	The reflection groups will provide support for team managers / leaders, 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 six one-hour groups. The group will involve team managers and leaders from several intervention teams. Meetings will be organised and facilitated by two 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 groups will comprise:
1	Group 1: Identify anticipated blocks and enablers, organise dates for remaining meetings
3	Group 2: Review progress, share experiences, solve problems.
6	Group 3: Review progress, share experiences, solve problems.
9	Group 4: Review progress, share experiences, solve problems.
12	Group 5: Review progress, share experiences, solve problems.
15	Group 6: Review progress, share experiences, solve problems.

Month	Implementation Strategy 5: Team reflection sessions
	A one-hour team reflection session will be held every two months. The group will cover progress in implementing the intervention, enablers and challenges to progress, reflection on stories of people's recovery, and actions needed to make further progress. Some meetings will be organised and facilitated by two trainers (one from a professional perspective and one from a lived experience perspective), and some will be self-organised by the team, with sessions moving over time from being facilitated to being self-organised.
2	(Facilitated) Identify anticipated blocks and enablers, organise dates for remaining meetings.
4	(Facilitated) Review progress, share experiences, solve problems.
6	(Self-organised) Review progress, share experiences, solve problems.
8	(Self-organised) Review progress, share experiences, solve problems.
10	(Facilitated) Review progress, share experiences, solve problems.
12	(Self-organised) Review progress, share experiences, solve problems.
14	(Self-organised) Review progress, share experiences, solve problems.
16	(Self-organised) Review progress, share experiences, solve problems.
18	(Self-organised) Review progress, share experiences, solve problems.

Month	Implementation Strategy 6: Supervision reflection
2-18	Supervision will 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 9) at each supervision. It can be used either for personal reflection or – where possible – for discussion in the supervision meeting.

6.2 Outline timetable

Figure 2 shows how the intervention will be implemented over the 18 months.

Implementation strategy	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Timeframe – Months																		
1. Information sharing	■																	
2. Personal recovery training	■	■			■													
3. Coaching and working practice training	■	■	■															
4. Team manager reflection groups	■	■		■		■			■			■			■			
5. Team reflection sessions		■				▣	▣	▣		■		▣	▣	▣		▣	▣	▣
6. Supervision reflection		▣	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣	▣

Figure 2: Timetable for implementation

■ Provided to the team

▣ Self-organised by the team members

Appendices

Appendix 1: REFOCUS information sheet

Information for individuals who use services about the REFOCUS Study

Recovery

You may have heard about changes in mental health services to support people's recovery. Recovery means[1]:

"A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness".

In other words, recovery involves living as well as possible.

The REFOCUS Study

Your team is taking part in a research study which aims to improve the way the team supports your recovery. The team are all receiving training in working with you to understand better a few things about you:

- Your **values** – the things you would like us to know about you, so we can respect these values in our work with you

- Your **treatment preferences** – how you would like us to provide any treatment or care

- Your **strengths** – so we understand what you are good at, and what supports in your life you have or would like to have

- Your **goals** – what matters to you, so that we can work together around the goals that matter to you.

All of these are important ways we can better support your recovery.

What can you do?

1. Please think about what would be helpful for us to know about your values, treatment preferences strengths and goals

2. If you want to, then please write something down to show your worker when you meet – the more that comes from you, the better!

3. If you're not being asked about these important areas then please remind us – we are trying new approaches and you can help us!

4. When we plan actions with you (at Care Programme Approach (CPA) meetings or other meetings) we want to make sure that plans are based on what you want – so please tell us if we've misunderstood your goals or are not working in the best way with you.

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1. Anthony WA (1993) Recovery from mental illness: the guiding vision of the mental health system in the 1990s, Innovations and Research, 2, 17-24.

Appendix 2: Partnership project proposal form

PARTNERSHIP PROJECT PROPOSAL FORM

Project Title:	
Project description Please explain what you would like to do.	
Project benefits Please explain how the project fits with recovery values.	
Project Team Please identify who will be involved in planning the project (must include at least one person using the service and one staff member).	
Project costs You may apply for up to £500 to cover the costs of equipment, venue hire, travel and subsistence expenses etc. Please outline what you intend to spend the money on.	**Total budget required:**

Appendix 3: Values and Treatment Preferences (VTP) interview guide

Name of person using the service: _____

Name of worker: _____

VALUES

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, parent's background...
Tell me a little bit about your self 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?

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 preferences? For each area above, what support if any would you like? How would you like workers to work with you?

Appendix 4: Additional resources for understanding values

Understanding the values of others is underpinned by an understanding of one's own values. Here are two exercises for workers which can help individuals to recognise and consider their own personal values. The exercises below may be done individually or in a group.

Understanding Values Staff Exercise[12]

Imagine you are an unseen observer in a training course in a country with a cultural heritage very different from your own. In this course a lecturer describes to the local people how people from your country behave. In their description they refer to:

- Eating patterns
- Preferred diets
- Typical social life
- Major cultural preoccupations (e.g. typical conversations amongst acquaintances)
- Specific tell-tale mannerisms or behaviours that distinguish your cultural group

First note what you feel the lecturer might say about each of these areas. Second note down on a scale of 1 to 5 the closeness of the descriptions to your own behaviour or experience with 1 representing the closest match and 5 the furthest.

Staff Personal Awareness Exercise[13]

Aim
Increased awareness of one's own values and beliefs

Instructions
Think about or discuss the following questions for

 i)   ethnicity
ii)   culture
iii) spirituality
iv) gender
v)   sexuality
vi) social roles

- How would you describe you in terms of i) to vi)?
- What do you see as the advantages and disadvantages of your experience?
- How do you think people using the service perceive you in terms of i) to vi)?
- How do you think this may affect your relationships?

Electronic resources

Personal narratives

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

Life maps

- www.docstoc.com/docs/947552/FREE-Mind-Map-Templates – mind mapping templates
- www.mindmapinspiration.co.uk – examples of completed mind maps.

Appendix 5: 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, or 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 spend?	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 of your life you would like to have more support in?	e.g. Have you ever belonged to any groups, clubs and/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 change regarding your health? 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 6: Strengths worksheet checklist

This checklist give some example prompt questions for areas to discuss in completing the Strengths Worksheet. The checklist has been adapted from elsewhere[9], 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, food shopping etc.).

Desires and aspirations:

- Where would the person like to live?

- Do they like living alone / with others?

- Desired changes to the living situation.

- 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?

- 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.).

- 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, college and educational activities, helping others, job searching, involvement with services, care giving etc.

- Education (achievements, likes, dislikes).

- What does the individual like about their occupations (educational, vocational and leisure).

- What is important to the person about their current occupations.

- 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, go to college, 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?

- Organisation, clubs or groups they participate in.

- What things does the individual do with others?

- Pets.

- Types of social support available e.g. family, friends, significant others, mental health workers, religious leaders and members of religious groups, 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 used 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.

- 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?

- Has the individual completed a Physical Health Check?

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 7: Additional resources for assessing strengths

It can be helpful for workers to identify their own strengths, to give them practice and insight into the experiences of people using services being asked to identify strengths. The exercise below, modified from elsewhere[8], is designed to help with this.

Exercise for workers

What is my identity?
This might include age, gender, race, culture, ethnicity, job titles and important roles in your life.

What are my hobbies, interests and passions?
List all the areas of life you care about and have interests in.

What are my skills, talents and resources?
List the things that you can do, what you are good at, and what you enjoy. What kinds of resources or equipment do you have access to?

What are my gifts?
What do people say about you? Why do they like you? What attracts people to you? If you were not here, what would be missing in your absence?

What support do I have in my community?
What is my community – which group(s) am I 'at home' with? What kinds of help do I get from my community? How do I help my community?

Appendix 8: REFOCUS clinical information record example and templates

These three forms are completed by intervention teams in the REFOCUS Trial.

Values and treatment preferences

After discussing the person's values and treatment preferences, record these here. 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; and Treatment preferences

> X identifies herself as a Black British woman. Although both her parents were born in Nigeria, X was born in the UK and has not been to Africa, so identifies herself as British. The ethnicity of staff does not matter to X, however she would prefer to have a female worker as she believes they will understand her and her physical needs better. X 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. X 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. X attends a range of services and likes to have different options, and control over the places she attends. This includes having access to a BME specific service if and when she wants it. In the past X was only offered a BME specific service but this did not suit her need and values, 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*
> X lives independently in a one-bed flat.
>
> *Financial*
> X manages her finances independently and budgets responsibly. She hopes to save enough money for a holiday next year.
>
> *Occupational e.g. educational, vocational, leisure*
> X has enrolled at college and attends a part-time course. She has also recently attended after-college activities.
>
> *Social supports*
> X has made new friends at college and is building her confidence in meeting new people.
>
> *Health e.g. mental health / physical health*
> X self-manages all health needs. She has learnt to ask for support if she feels she needs it.
>
> *Spiritual and cultural*
> X 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:** X would like to continue to build her confidence in meeting new people at college
>
> **Goal 2:** X would like to use other strategies besides medication to manage her illness
>
> **Goal 3:** X would like to attend a local church or Christian group.

Appendix 9: Supervision reflection form

Please use this form as a prompt to reflection before each supervision meeting. 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 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 and treatment preferences inform their care plan?

- How is the care plan amplifying their strengths?

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