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Thinking about recovery and well-being in a social context

Recovery has often been defined as a “personal” journey (see Anthony, 1993). The concept itself rose from the work of people who have themselves experienced the challenge of rebuilding their lives with mental health challenges (see e.g. Chamberlin, 1977; Deegan, 1988). However, many have described a professional “take over” of the concept and the way in which it supports a politically neoliberal agenda (Perkins and Slade, 2012; Rose, 2014). Too often, problems are located within the individual and it is seen as the individual’s responsibility, to find hope, take back control over their life and access opportunities they value: the social, political and economic context of recovery and all the discrimination and oppression that people face are minimised or ignored.

“Wellbeing” is another construct that risks the same fate, as has the concept of “resilience”. Too often, poor health (physical and mental) are attributed to “life-style choices” that the person has made: if only we stopped our lives of indolence – the lack of exercise, smoking and drinking that lead to idleness and obesity – and followed the “five ways to wellbeing” then our well-being would be assured. Similarly, “resilience” is too often seen as the personal strategies that a person has developed for coping with the vicissitudes of life. Both emphasise “personal responsibility”. The social determinants of health, well-being and resilience (like having a decent place to live, friends, a partner, a family, the chance to do the things you value, a good job, etc.) and community though well documented (see Marmot, 2015) receive but scant attention.

Neither “recovery” nor “well-being”, nor “resilience” occur in a vacuum: they occur in the context of a family, a community, a culture, an economic, social and political environment. These go a long way in determining values and aspirations, the meaning of the challenges that a person faces as well as the resources and possibilities for rebuilding a meaningful, valued and satisfying life, as well as maintaining health and well-being.

This is not to say that individuals cannot change, or that personal responsibility has no role:

[...] personal responsibility should be right at the heart of what we are trying to achieve. But people’s ability to take personal responsibility is shaped by their circumstances. People cannot take responsibility if they cannot control what happens (Marmot, 2015, p. 51).

Poverty, unemployment, loneliness and poor (or no) housing are not a “life-style” choice. They are circumstances in which a person is deprived of control over their life and their possibilities for taking “personal responsibility” are severely constrained.

In this context, if services are to promote recovery and well-being we must first review their purpose: from “getting rid of problems” to enabling people to “get decent lives”. Indeed, surgeon Atul Gwande (2014) argues that this should be the primary purpose of health and social services:

We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being – and well-being is ultimately about sustaining the reasons one wishes to be alive [...].

Medicine must shift from a focus on health and survival to a focus on well-being – on protecting, insofar as possible, people’s abilities to pursue their highest priorities in life (Gwande, 2014, p. 7).

This is not dissimilar to the New Zealand definition of recovery “living well in the presence or absence of one’s mental illness” (O’Hagan, 2012, p. 1) which encapsulates both recovery and well-being.
Second, services need to think about shifting the balance of their efforts. Move from changing individuals so that they fit in, and a focus on “personal responsibility, to changing their circumstances and creating inclusive communities that can accommodate all of us: communities in which everyone can participate as an equal citizen. From an “I” society to a “we” society. Too often, when we think of “we” we think of “people like me”. Such “identity politics” has been really important in identifying and fighting oppression, prejudice and disadvantage. However, as an organising principle for communities it leaves much to be desired. It risks creating warring sectors of like-minded people who have little contact with, or understanding of, each other. It requires people to identify themselves in terms of an overarching, defining characteristic (e.g. mental health service user/survivor) and obscuring other identities and roles. Just as in the old asylums, the identity of mental patient risks eclipsing all other facets of identity and personhood. Most people have multiple roles and identities (see Fanshawe and Sriskandarajah, 2010). The real challenge is to create communities that accommodate and celebrate diversity and enable people to inhabit multiple roles and identities. To understand individual recovery and well-being, we must understand this rich complexity.

If services are to better assist people in their journey of recovery and promote well-being and resilience we need both to address the social determinants of health and foster more inclusive communities.

The social determinants of health and well-being

Typically, advice relating to health and well-being adopts the clinical approach that is prevalent in health services. However, research relating to the underlying determinants of health and well-being derived from the field of public health tells a very different story. This contrast is amply illustrated Gordon (n.d.) of the Townsend Centre for Poverty Research at the University of Bristol who have contrasted the Chief Medical Officer’s “Ten Tips for Better Health” with alternative, evidence based, tips that consider the social determinants of health and well-being (Table I).

As Marmot (2015) observes:

Hard to argue with any of the first, public health, list; it is all very worthy, well-meaning, based on sound advice […] and unlikely to make much difference. “I was about to drink and drive and have unsafe sex and then, just in time, I remembered the Chief Medical Officer’s advice”. “I was about to feed the children takeaway chips. But remembered the one about fruit and vegetables, so gave them a salad and fresh fruit instead”. “I’m worried about losing my job. Which probably means losing my flat, pretty stressful, but I make time to relax so it’s all right now”. The problem with the public health list is not that it is wrong – but that simply conveying advice is unlikely to lead to change in those who have most to gain (Marmot, 2015, p. 50).

Table I  Ten Tips for Better Health

<table>
<thead>
<tr>
<th>The Chief Medical Officer’s Ten Tips for Better Health</th>
<th>Alternative Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do not smoke. If you can, stop. If you cannot, cut down</td>
<td>Do not be poor. If you are poor, try not to be poor for too long</td>
</tr>
<tr>
<td>2. Follow a balanced diet with plenty of fruit and vegetables</td>
<td>Do not live in a deprived area. If you do, move</td>
</tr>
<tr>
<td>3. Keep physically active</td>
<td>Do not be disabled or have a disabled child</td>
</tr>
<tr>
<td>4. Manage stress by, for example, talking things through and making time to relax</td>
<td>Do not work in a stressful low-paid manual job</td>
</tr>
<tr>
<td>5. If you drink alcohol, do so in moderation</td>
<td>Do not live in damp, low quality housing or be homeless</td>
</tr>
<tr>
<td>6. Cover up in the sun, and protect children from sunburn</td>
<td>Be able to afford to pay for social activities and annual holidays</td>
</tr>
<tr>
<td>7. Practise safer sex</td>
<td>Do not be a lone parent</td>
</tr>
<tr>
<td>8. Take up cancer screening opportunities</td>
<td>Claim all benefits to which you are entitled</td>
</tr>
<tr>
<td>9. Be safe on the roads: follow the Highway Code</td>
<td>Be able to afford to own a car</td>
</tr>
<tr>
<td>10. Learn the First Aid ABC: airways, breathing and circulation</td>
<td>Use education as an opportunity to improve your socio-economic position</td>
</tr>
</tbody>
</table>

Source: DoH (1999)

Source: Townsend Centre for International Poverty Research, University of Bristol
How many clinicians can honestly say that the people who use their services have really heeded their advice to stop smoking, and drinking, eat healthy food and get lots of exercise? Efforts to encourage people with mental health problems to stop smoking are not new, yet in England 40.5 per cent of adults with serious mental health problems continue to smoke (as compared with 14.9 per cent of the general population)[1].

In thinking about health (both physical and mental) and well-being, we need to move beyond encouraging people to adopt “healthy lifestyles” and address the social determinants. We know that, for example, loneliness is very bad for not only mental health but physical health. In their meta-analysis of the relationship between social relationships and mortality, Holt-Lunstad et al. (2010) showed that stronger social networks and social integration increases your likelihood of survival by 50 per cent. Social isolation is worse for your chances of survival that obesity, lack of exercise and alcohol and on a par with smoking:

Physicians, health professionals, educators, and the public media take risk factors such as smoking, diet, and exercise seriously; the data presented here make a compelling case for social relationship factors to be added to that list (Holt-Lunstad et al., 2010, p. 14).

Similarly, the social determinants of health are also the social determinants of recovery. It is very hard to find hope, take back control over your life and access to opportunities you value if you are living in poverty, in a deprived area where crime is rife, with few, if any, friends and social contacts and where the prejudice and discrimination you face make social and economic participation difficult, if not impossible. Your ability to take “personal responsibility” is severely limited by your circumstances – unless we address these circumstances.

What does this mean for mental health practice? It means that we should spend as much, if not more, effort in changing a person’s circumstances as we take in changing the person. This might include, making sure that people have all the welfare benefits to which they are entitled, responding to government consultations that threaten to further disadvantage people living with mental health challenges, promoting social networks (including peer networks) in people’s chosen communities, challenging prejudice and negative stereotypes, helping people to access opportunities they value, using our influence to help people fight for better housing, etc.

Fostering inclusive communities

If recovery and well-being are about “living well” then, as Gwande (2014) says, this must include “sustaining the reasons one wishes to be alive” and a “protecting, in so far as possible, people’s abilities to pursue their highest priorities in life” (p. 7). This must centrally involve enabling people to access opportunities you value.

Being valued as an equal citizen is important to most people and this requires not only having access to opportunities that exist within communities, but also the right and opportunity to contribute to those communities. Always being on the receiving end of help and support from others is not, for most people, their highest priority or reason for being alive, and it can be a demoralising and demeaning place to be. Yet most mental health “care plans” focus exclusively on how people can get the help they need to resolve their problems rather than on the support they need to use their talents to contribute to their family, network and community. Work is obviously one way in which people can contribute to their communities (and have this contribution recognised and valued in the form of payment) and thereby become linked to their communities, and many people want a job. However, there are many other ways, large and small, of contributing to the life of your family and community (via, e.g. politics, art, contributing to the activities of faith communities and simply helping others out) and these may be equally important in promoting recovery and well-being.

The challenge is to move to a situation where people living with mental health challenges are valued citizens who are agents in their own lives, rather than being seen as the objects of pity, charity, health and care to whom things are done.

In order to promote inclusion and citizenship, the “clinical model” typically adopted within health services focuses on changing people so that they “fit in”; treatment and therapy to reduce disruptive “symptoms”, confidence building, skills training, etc. However, within the broader
disability movement, people with mobility and sensory impairments have long concluded that this approach has limited value in enabling people to live well as part of their communities. Instead they adopted a “social model” of inclusion which argues that people are not disabled by their supposed impairments but by the barriers they face in society:

It is attitudes, actions, assumptions – social, cultural and physical structures which disable by erecting barriers and imposing restrictions and limiting options […] The social model of disability is about nothing more complicated than a clear focus on the economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment […] (Oliver, 2004, p. 6).

Thirty years ago, Patricia Deegan, one of the pioneers of concepts of recovery recognised the parallels between her own experience of a diagnosis of schizophrenia and others who faced physical impairments (see Deegan, 1988). She too, argued that:

[…] having a psychiatric disability is, for many of us, simply a given. The real problems exist in the form of barriers in the environment that prevent us from living, working and learning in environments of our choice […] [the task is] to confront, challenge and change these (Deegan, 1994, p. 9).

Disability activists have ensured that this social model is backed up by rights. At an international level, the right to participate fully in all facets of community life and the right to the support necessary to do this are enshrined in the United National Convention on the Rights of Persons with Disabilities (2006) and in the UN we have the Equality Act (2010). This not only outlaws discrimination (direct and indirect) but also requires that employers, education providers and the providers of goods and services to make “reasonable adjustments” to ensure access for people with the full range of impairments (including mental health challenges):

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

This type of social model of inclusion- and rights-based approach offers an alternative to a clinical approach that has proved highly effective in ensuring the greater participation in all facets of community life for people with a range of impairments, yet it has received relatively little attention within mental health services.

A social- and rights-based approach to inclusion requires us to think differently. To replace the question “what are a person’s problems and how can we get rid of these” with “what are the barriers (attitudes, expectations, assumptions, social, cultural and physical structures) and how can we get around these”:

- What sort of support might the person need? (the mental health equivalent of the wheel chair, the assistance dog, the sign language interpreter, etc.).
- What adjustments might the person need? (the mental health equivalent of the ramp, the hearing loop, signs in braille, etc.)
- How can we enable people to know and assert their rights?

Aids, adaptations and adjustments for people with physical impairments are relatively well developed and are primarily directed towards enabling people to access the physical world. Those for people with mental health challenges are less well developed and often need to be directed towards enabling people to access the social world.

Mental health services do not hold the key to inclusion and citizenship. Indeed, the presence of extensive professional services (both statutory and non-statutory) may mitigate against inclusion. As Mary O’Hagan has observed, such services tend to make individuals believe that they need professional help to put things right. Their nearest and dearest think that we are not safe in their untrained hands – better to leave it to the experts, and so our communities become less and less able to accommodate human distress. As Warner (2009) illustrates, it is noteworthy that outcomes for schizophrenia are better, and mortality for people with schizophrenia is lower, in the developing world where there are fewer professional services […] but as such services are developing, so mortality is increasing.
However, it is possible that mental health services could become better catalysts in facilitating recovery, participation. To do this, we must “think beyond service land”, for example:

- Understanding people and their challenges and aspirations in the context of their community and culture.
- Moving beyond thinking about “the person in our services” (and what we can do to put right their problems) to thinking about “the person in their life”: where they have been, what has happened to them, where they are now, what they have got going for them, where they want to get to (and what help they need to use what they have got going for them to get from where they are now to where they want to be).
- Moving away from a focus on what we have to offer and considering people’s own resources and resilience (many have shown extreme courage and ingenuity to just keep going in the face of the things that they have experienced), their existing circles of support and the opportunities and resources available in communities.
- Helping the person to think about the support and adjustments they may need to do the things they value […] and helping them to negotiate these and assert their rights.
- Recognising what already exists in families, social networks and communities and thinking about how we can learn from and support this.
- Supporting family, friends, people and agencies in communities: inclusion involves a relationship between the individual and their community and we need to think about supporting both sides of the relationship.

To conclude

There is a tendency for the concepts of recovery, well-being and resilience to be seen in highly individualised terms: a person must “take responsibility” for their own recovery and life-style choices and developing strategies for coping with the vagaries of life. This reinforces a neoliberal agenda and runs counter to the wealth of evidence that the social determinants of health, well-being, recovery and resilience.

Well-being and recovery are intimately interlinked. Recovery is about “living well”, pursuing your highest priorities in life, and both require that we have the resilience to cope with what life throws at us. However, these are not divorced from the personal, social and economic context we face. Our circumstances determine the extent to which we have control over our lives and can exert “personal responsibility”. The rebuilding of a valued and satisfying life that is the essence of recovery occurs in the context of a community, a culture, a material, social, economic and political environment which has a significant impact on our values and aspirations and the resources and possibilities open to us.

Mental health services must understand recovery and well-being in a social, cultural and community context. We must move from a primary focus on trying to change the individual to thinking about this context and how we can change the circumstances in which people live and create communities so that can accommodate all of us – including those of us who live with mental health challenges.

Note

1. https://fingertips.phe.org.uk/search/smoking%20and%20mental%20health#pat/6/ati/102/par/E12000004

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Further reading


Research watch: men’s social inclusion and suicide prevention

Sue Holttum

Abstract
Purpose – The purpose of this paper is to explore recent research on reducing suicide, especially in men, who are often seen as excluding themselves from needing support, or they are excluded because people think they do not want it.
Design/methodology/approach – A search was carried out for recent papers on suicide prevention in men.
Findings – One study of 75 regions of Europe reported a link between higher value on giving social support and lower suicide rates, especially for men. Another study reported on the fall in a previously high suicide rate, especially in men, in Quebec province in Canada. A programme of suicide prevention may have contributed to this reduction. Finally, a small interview study reported on how certain kinds of encounters with professionals can inspire hope to carry on after a suicide attempt.
Originality/value – The two papers looking at regions (across Europe and one province of Canada) suggest how social forces may contribute to reducing suicide, especially in men. The Canadian study suggests the possibility that suicide might be reduced partly by enabling help-seeking in men to be seen as a positive aspect of masculine identity, rather than seeing masculinity as excluding men from support. The small qualitative study illustrates vividly how individual encounters after a suicide attempt might promote hopefulness and are relevant to both sexes.
Keywords Masculinity, Social inclusion, Suicide prevention, Help-seeking, Men
Paper type Viewpoint

Three recent papers have examined the issue of suicide. First, I describe the findings of Sedivy et al. (2017), who looked at 75 regions across Europe. They wanted to see if fewer people kill themselves in places that have a greater culture of giving support, compared to places where the tradition is more that people fend for themselves. They also looked at men and women separately, because of higher suicide rates in men. The second paper (Roy et al., 2018) discusses recent policy changes in Quebec, a region of Canada. These changes appear to have reduced the rate of male suicide compared to other parts of North America. The third paper (Vatne and Naden, 2018) reports on a small-scale study in which the researchers interviewed people who had recently tried to end their lives. They asked what helped them to carry on afterwards.

Are men more likely to take their own lives if they live in a “fend-for-yourself” culture?
Sedivy et al. (2017) begin by highlighting the higher suicide rates in men than women worldwide. However, some regions of the world have lower overall suicide rates than others, so the authors wondered whether the differences might be a clue to what might reduce suicide, especially in men. Although the causes of suicide are complex, Sedivy et al. (2017) wished to focus on one of the things that may contribute: the societies and cultures that surround people. A person’s connection to social networks, suggest Sedivy et al. (2017), protect people from suicide because these networks enable people to feel both that they can receive support and that they are contributing to others.

Social support and suicide
Sedivy et al. (2017) wanted to look at suicide rates in different places, and see if they could find any links with a measure of community valuing of support-giving at the level of regions within
Europe: specifically, they were interested in whether regions with higher valuing of support-giving would have lower suicide rates, and whether things were different for men and women. Previous research, they say, has looked at whether available support is linked to lower suicide and found it is. However, a community’s general level of valuing support-giving may also be important, they suggest. If it is not valued, even available support may be under-used.

Men are less likely to seek help than women

Sedivy et al. (2017) use Joiner’s (Joiner, 2005; Joiner et al., 2009) interpersonal theory of suicide, in which “lack of belongingness is one of the two conditions crucial for” people thinking about suicide (Sedivy et al., 2017, p. 41). The other one is feeling a burden on others. If a local community values supporting others, then people may feel less that they are burdening others by seeking help, suggest Sedivy et al. (2017). They highlight research showing that men are less likely to seek help than women, and they suggest this is partly due to the stereotype of masculinity, which may lead men to believe that seeking help for mental health problems implies weakness. Sedivy et al. (2017) wonder if more men might seek help if they live in communities that value highly the giving of support, and by implication, receiving it.

Working out whether there is less suicide in communities that value support-giving

Sedivy et al. (2017) obtained suicide rates (2012–2014) from a European database (Eurostat, 2017). To understand community values, Sedivy et al. (2017) used data from the European Social Survey Round 6 Data (2014), which asked people across Europe about “Well-being, values and attitudes” (Sedivy et al., 2017, p. 41). The European Social Survey had responses from 20,488 men and 23,750 women across 75 regions in 23 countries, including the UK. A single question from the survey was used to indicate the valuing of support-giving. The question described someone who values giving support to those around them, and asked people to rate how similar to themselves this person was, on a six-point scale. Other data Sedivy et al. (2017) used from the European survey included average satisfaction with life for men and women, and countries’ economic output in the form of gross domestic product (GDP) per head. They obtained alcohol consumption by country and gender from a World Health Organisation (2017) database.

In order to see if a community’s valuing of support-giving predicted suicide rates, Sedivy et al. (2017) used level of valuing support-giving as a predictor in their statistical analysis, and suicide rates in men and women as outcome variables. They wanted to control for regional life satisfaction, GDP and alcohol consumption. This means that they could find out how much a community’s valuing of support-giving predicted suicide rates if life satisfaction, GDP and alcohol consumption were the same across all regions. They are not the same, but this form of statistical analysis allows one to see the picture as if they were. If you find a link between higher valuing of support-giving and lower suicide rates, you can then rule out higher life satisfaction and GDP, and lower alcohol consumption, as possible causes of the lower suicide rates.

Is there a link between higher community valuing of support-giving and lower suicide rates?

Valuing of support-giving was on average on the positive side of the scale (people were more likely to value it than not), but Sedivy et al. (2017) reported the lowest valuing of it for Lithuania and the highest for the Isole region of Italy. The lowest suicide rate was reported to be among women in Cyprus (less than 2 per 100,000 over three years), and the highest was reported for men in Lithuania (more than 58 per 100,000 over three years). For both men and women, there was a link between higher community valuing of support-giving and lower suicide rates, but the link was stronger for men than women. Sedivy et al. (2017) then controlled for life satisfaction, GDP and alcohol consumption. These things also accounted for some of the variance in suicide rates in men.

Sedivy et al. (2017) suggest that their findings indicate the potential importance of increasing a community’s valuing of support-giving for reducing men’s suicide rates. It also seems that a region’s alcohol consumption and country’s GDP may contribute to men’s suicide rates, but not women’s. A note of caution that Sedivy et al. (2017) mention is that this was a correlation study,
and from this type of study it is not possible to be sure whether a region’s valuing of support-giving is the cause of lower suicide rates, or lower suicide rates in a region encourage more support-giving. This is perhaps unlikely, but not impossible. It could also be that a country and region’s lower economic performance leads to its citizens’ lower life satisfaction, for example due to more unemployment, and thence to more alcohol use, hopelessness and suicide, as well as reducing people’s feeling of being able to support others.

Furthermore, as Sedivy et al. (2017) point out, the use of a single questionnaire item to measure valuing of support-giving is not as good as using a full and well-validated questionnaire. Sedivy et al. (2017) mention other limitations of their study, such as variations in how suicide is recorded in different regions. However, it seems likely that communities’ valuing of support-giving might be important and a possible avenue for reducing suicide, especially in men.

**Has a region in Canada been able to reduce men’s suicide?**

Roy et al. (2018), like Sedivy et al. (2017), note that more men end their lives, worldwide, than do women, and they are specifically concerned with their local region, the province of Quebec in Canada. In this region, they report, men’s suicide is also higher than women’s. They report that it increased more than in women between 1981 and 1999, especially in middle-aged men. Roy et al. (2018, p. 137) note the paradox of men’s “privileged position” in society and the reality of many men’s “distress, suicide, substance abuse, and homelessness” that social workers see, and men’s reluctance to seek help.

Roy et al. (2018) point out that men’s suicides, having risen up to 1999–2000 in Quebec, fell by 42 per cent up to 2013. Women’s suicide, which was lower in any case, fell by 33 per cent over the same period. The decrease in male suicide for the rest of Canada was smaller, at 18 per cent, although it started off lower than in Quebec province. Rates rose by 2 per cent in women in the rest of Canada, say Roy et al. (2018). Despite the 2007 recession, men’s suicide rates still fell in Quebec, compared to a rise in the USA, especially in 2007. Roy et al. (2018) mention a British study (Ban et al., 2012) that reported a rise in men’s suicide rates of 1.4 per cent for every 10 per cent rise in unemployment. This echoes the effect of unemployment in other countries, say Roy et al. (2018), so they wonder what is different about Quebec province, which was also affected by the recession.

**What does it take for men’s suicide to be addressed?**

Roy et al. (2018) point out that the increase in men’s suicide before the year 2000 had been largely ignored by policy-makers until some prominent cases were reported in the media in the late 1990s. A coroner suggested in relation to a 1997 case of domestic murder and suicide that society’s response to men’s distress was inadequate, say Roy et al. (2018). At the time, “talking about distress in men was quite uncommon” (Roy et al., 2018, p. 138). Then between 1999 and 2000, the suicides of two public figures were prominent in the media: those of a rock singer and a TV reporter. This appeared to motivate policy-makers to do more. An agency for men’s health was created within a government ministry, and 12 pilot projects on men’s suicide prevention were set up in Quebec province. There were also new services for men who behaved violently, for substance misuse and to support fathers.

**Does strong masculine identity contribute to men’s suicide?**

Roy et al. (2018, p. 139) note that in the beginning, people asked, “What’s wrong with men?” The gender stereotype of masculinity was seen as harmful in that, in western societies, it emphasises “competition, aggression, heterosexuality, and denying femininity” and can see help seeking as weak (Roy et al., 2018, p. 139). However, Roy et al. (2018) pointed out that some people had criticised this view of masculinity as focusing on the negative aspects of it and on mental health problems rather than well-being. Roy et al. (2018, p. 139) note that social work practices and values are about “seeing the person behind the problem”. When you focus on masculinity as a problem, you see help-seeking as unusual and you do not expect it. Strength-based practices enable you to more easily see men as individuals, and many do seek help.
What helps men to seek help?

Roy et al. (2018) point to Robertson’s (2007) men’s health model. This theory explains that men find ways to get round the problem of traditional masculinity in order to seek help when they need it. For example, they may view being a good father or a good citizen as entailing taking responsibility for their health. Thus, men seeking help can be seen as strong, not weak, and in this sense as part of masculinity. Roy et al. (2018) describe a social work study of male farmers in Quebec province (Roy et al., 2015). In that study, farmers who were able to seek help and had a good experience then became role models for others. Farmers, say Roy et al. (2018, p. 140), are seen as “tough, rugged, fearless, hard-working family men”. This, however, did not prevent them from seeking help, and such behaviour could then be seen by services as masculine behaviour adapting to the situation in hand, as opposed to masculinity being a barrier.

Seeking help as a sign of strength

Roy et al. (2018) describe a men’s suicide prevention project that started in 1996. The project drew on research and also focus groups. The first part of it used a range of media outlets and had the slogan “Seeking help is strong!” There were four aims, say Roy et al. (2018):

1. a simple message;
2. different ways to be masculine;
3. stigma reduction concerning mental distress; and
4. promoting men’s well-being.

The second part of the project involved training professionals in both services and male workplaces. The third part of the project was setting up self-help groups for men facing adversity, say Roy et al. (2018). A professional would run them at first and then hand over to a group member. The project was evaluated positively, say Roy et al. (2018). According to Roy et al. (2018), over 4,000 professionals have been trained in the past 15 years to take a more positive approach to men seeking help in Quebec province, for example moving away from assumptions based on the male gender stereotype, focusing positively on men’s strengths, offering evening opening hours and following up more often.

Roy et al. (2018) suggest that society, services and men need not be trapped by focusing on restrictions that can come with a strong masculine identity. Masculinity can include seeking help when it is needed. Even so, say Roy et al. (2018), some men are still somewhat neglected when it comes to services. Among these they list fathers, military men, migrants and asylum-seekers.

Regaining hope after a suicide attempt

Although Vatne and Naden (2018) do not consider male suicide specifically, their small qualitative study sheds light on an important question, by reporting what people said about how they regained hope after attempting suicide. Their sample of ten people included both men and women. Like Roy et al. (2018), Vatne and Naden (2018) refer to the work of Joiner (2005), pointing out that not feeling one belongs and feeling a burden on others increases people’s risk of suicide. Because people who are feeling suicidal believe that there is no hope, say Vatne and Naden (2018, p. 445), professionals need to “become involved in their suffering” and to inspire hope.

People do not always talk to someone in their social network when they are having difficulties, say Vatne and Naden (2018), but aside from professionals, social networks are very important, and being able to have support from someone in this network can be vital. Despite some previous research, there had not been much on what helps in service contexts after a suicide attempt, so Vatne and Naden (2018) set out to find out from people who had experienced this.
Interviews with people who had tried to end their lives

Vatne and Naden (2018) report on interviews with four women and six men with age ranges 21–52 years, who had recently attempted suicide in Norway. Some had recently gone through relationship breakups. One was working and two were in education or training. Five were on sick leave and three were on disability benefits. One had been prevented from completing suicide by compulsory admission to a mental health unit. The interview covered the following questions:

- how the person came to the mental health services;
- views of encounters with professionals;
- views about treatment offered;
- whether professionals could do anything differently;
- what would help in coping with feeling suicidal; and
- what people might do to help themselves.

What helped people after a suicide attempt?

Vatne and Naden (2018) analysed the interview data using thematic analysis. They report three themes, and these will be described next, with a flavour of the kinds of things their participants said.

“Experiencing hope through encounters” (Vatne and Naden, 2018, p. 448): this theme illustrates how participants appreciated professionals who seemed to really listen and understand them, and also how alienating it could feel when they did not feel heard. One participant noted how helpful it was that a professional recognised her difficulty finding words, and gave her time. A male participant appreciated when a nurse, who had got to know him, recognised from his body language that he was becoming angry in an encounter with a psychiatrist. The nurse took the psychiatrist aside, and then they came back later and resolved the situation in a way the participant found helpful. Participants also found it helpful hearing other patients talking about their own difficulties, as they felt less alone. One participant was negatively affected in a ward where patients were restricted from talking to each other. Various encounters could inspire hope, from feeling less alone, feeling heard and feeling understood.

“Experiencing hope through the atmosphere of wisdom” (Vatne and Naden, 2018, p. 450): this theme is about the general feeling of a service context. A young male participant experienced a caring attitude from nurses in the emergency room. He sensed that they really cared. It prompted him to think about possibly choosing life over death. Another man, on entering the emergency mental health unit, sensed a calm and caring stance from the professionals, and he could feel it even in the midst of deep depression. A female participant talked about entering a room devoted to creative activities in the mental health unit. Despite not feeling good at art or craft, she felt “there is so much soul in that room […] almost as though you have entered a holy place, you become a bit, like, inspired by just sitting there” (Vatne and Naden, 2018, p. 450). This participant did do some crafts, and it helped her self-worth, and increased her hope. She then went to group therapy to increase her social confidence and started thinking about future possibilities and employment.

“Experiencing a ray of hope from taking back responsibility” (Vatne and Naden, 2018, p. 450): professionals helped people to develop coping strategies for their suicidal feelings. However, follow-up probing that only focused on suicide risk was not always experienced as helpful. For example, one man talked about wanting to focus on addressing his problems, and he went to a private therapist to work on these. Not only listening, but also feedback and guidance were appreciated. It was helpful to look at not only one’s “own patterns in thoughts and actions, but also own possibilities” (Vatne and Naden, 2018, p. 451). One female participant found a course on coping with depression helpful. She identified who in her social network could support her, and she felt more able to make choices. For some, drawing up a crisis plan seemed crucial. For one young man going on home leave, being trusted to keep to an agreement with a contact person in the mental health unit that he would not harm himself was key. The plan honoured his need to be trusted. However, it also seemed to be important that he had established a relationship with the contact person, who he felt respected him.
What services can do

Vatne and Naden (2018) suggest that there is a need to ensure that all professionals meet after a suicide attempt are able to maintain their own feelings of hope, and that there is a caring culture. This can restore hope in someone who is in despair. Vatne and Naden (2018) cite Cutliffe and Barker’s (2002) call to allow staff to communicate with people who are suicidal rather than just observe them. Certain kinds of communication with another can help people find new ways of coping with their difficulties, and see new possibilities and raise their hope for their future life. A crisis plan can help, drawing on the person’s self-knowledge of their risk-factors, and placing faith in their abilities to follow it through, with support from someone who knows them well.

Conclusions

Although the study by Vatne and Naden (2018) was small and involved both men and women, their findings appear broadly in line with discussions of male suicide in the other two studies, in that they highlight the importance of connection to others. Although it was true of women as well as men in Vatne and Naden’s (2018) study, the sense of being cared about, respected and trusted echoes the suggested need to believe that people want to give support in one’s community (Sedivy et al., 2017). Regaining a sense of control over one’s own coping may be seen as fitting in with the idea that seeking help is strong and in line with masculine identity (Roy et al., 2018), although it need not be exclusively masculine. It is a sign of how men and women can adapt to specific situations as they arise, and do not act only in accordance with their gender stereotype (Roy et al., 2018). A strong sense of masculinity, either held by men or by their surrounding culture, need not exclude men from seeking and receiving help when they need it. Perhaps a more difficult question remains: How well can services maintain a culture of caring and hope when resources are stretched to the limit? Who cares for the carers?

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Patsy Flanagan in conversation with Jerome Carson

Patsy Flanagan and Jerome Carson

Abstract

Purpose – The purpose of this paper is to provide a profile of Patsy Flanagan.
Design/methodology/approach – Patsy provides a short background to her life story and is then interviewed by Jerome.
Findings – Patsy shares with us a journey of suffering that started when she was only five, to today where she feels she has been saved by motherhood and would like to save others through her books.
Research limitations/implications – Case studies illustrate the complexities and the richness of human experience and help us understand mental health and mental illness better.
Practical implications – Patsy makes a heartfelt plea to those contemplating suicide, "I beg of you, reconsider. Life can improve".
Social implications – To tackle the mental health epidemic we are witnessing, Patsy says we must start conversations about mental wellbeing in childhood. Schools have a vital role to play.
Originality/value – Patsy states that creativity and empathy can arise from suffering. Her own story bears witness to this.

Keywords Education, Depression, Spirituality, Motherhood, Suicidality, JK Rowling

Paper type Case study

Introduction

I have known Patsy for three years. Over that time I have read and marked several of her essays. Sometimes that is how I get to know our students, through how they express themselves in their assignments. This often reveals their uniqueness of thought. Yet the story Patsy tells in these pages is not one that was familiar to me. How many of us hide the wounds we all carry, for no doubt a variety of good reasons? This blinds us to the richness of the human spirit and the triumph of survival against the odds. When I was a clinician I sometimes reflected that the only reason I sat on one side of the room and the client on the other was because I had experienced a certain set of circumstances that was more favourable to me than theirs was to them. Like many, I was always conscious of the saying, “There but for the grace of God go I”. Patsy had just such an unfavourable background, but let us hear the remarkable story that Patsy has to tell in her own words...

Brief biography of Patsy Flanagan

My earliest thought of suicide was aged five. There are some who would doubt the validity of this statement. Of course, I was unaware of the word “suicide” and I was not clear about what it meant to die. But I knew I did not want to be a person anymore, and I strongly suspected that it might hurt to achieve such. In comparison to the pain of life though, it felt preferable. My other early memories were of violence; screaming and tears and the crashing sounds of picture frames being thrown at walls. My mother crying. My sister, a toddler, also crying. My father, a terrifying tower of rage and me. And me an empty shell of a person who somehow felt responsible for it all.

We, my mother, my sister and I, ran away from that home in the middle of the night and although the thoughts of death stopped for a while, my mental health was still wavering. I had extreme anxiety for much of my childhood and continue to suffer with anxiety on occasion to this day.
I behaved erratically, obsessively cleaning bathroom walls at school and biting down on pencils so hard there would be shards of wood around my school desk at the end of each day. My teachers described me as a solemn and withdrawn child. My mother observed something was not quite right. And yet, mental health support was not then as readily available as in current times. As such it was suggested I was “probably just shy” and that I would “grow out of it”. Feeling abandoned to this monster that was consuming me from the inside out, I gave up, withdrawing inward further and further. I spent most of my childhood reading as a way to escape.

At 15, I discovered a way to self-medicate; alcohol. When I drank, I could suddenly socialise, the incessant voices in my head stopped, I could breathe temporarily. By 21, I was sneaking bottles of vodka into my bedroom at my mother’s house, hiding it in my wardrobe and taking a swig every time my anxious thoughts attempted to creep their way home into my brain. And it was at this age, 21, that I seriously attempted to take my life.

I was drunk, as was usual. But the alcohol just was not working anymore. Instead of fixing everything like it used to, now when I drank I became sadder. Less fearful. But desperately hauntingly sad. I was getting into arguments with family members, friends and my employers. I was spending money I did not have. I was daring myself to jump in front of trains, to hold my head under the water whilst I was in the bath, to buy a bottle of paracetamol from every shop I entered; just in case. On the night in question I had been drinking for approximately seven hours. I took a scarf and attached it to a ceiling hook, pulling down slightly as I did to test it. After I let my feet go there was only instant regret. No matter the pain of life, the pain of death is worse. There is the innate fight to survive, a feeling of pure panic. I got lucky. The hook on the ceiling came loose. I dropped to the floor, and my friend upon hearing the noise of me thud to the ground, ran into the room. He was, of course, horrified and forced me to see a doctor the next day.

I was diagnosed with severe depression. I was prescribed citalopram and referred to the local mental health team. Not to undermine the importance of both diagnosis and appropriate medication, but for me I found that the medication made me feel strange and “high” which I did not like. The turnaround in my mental state came in the form of spirituality. I cut alcohol out completely for a number of years, until I could exhibit better self-control. I took walks in nature. I meditated. I started keeping a journal, and writing poetry and reading again. I learnt to accept that anxiety was a habit I had cultivated over an entire lifetime. That it was ok to feel fear. Natural even. That I could control only my response to fear, and not the actual fear itself.

Two years after my suicide attempt, I gave birth to a beautiful and gregarious daughter. So full of life, so joyful that she is, it is my absolute belief she was sent to save me. She gave me purpose, a reason to not only survive, but to thrive. Inspired and motivated by my desire to make her proud, I returned to university. This year, 2018, as my daughter turned six, I graduated from the University of Bolton with a first class degree with honours in Psychology, Psychotherapy and Counselling. I am hoping to continue onwards with my education, to complete a master’s degree in social work or teaching, to be a voice for children like me who cannot see a way forward. I have also begun writing a series of children’s books based on the themes of mental health, grief and meditation. I am a huge believer that to tackle the mental health epidemic we are witnessing, we must start the conversations in childhood. Prevention is a better approach than treatment.

For anyone reading this in the grips of mental illness or who is considering suicide as a solution, please, I beg of you, reconsider. Life CAN improve. The pain you experience does not have to be something that defines you, or something that breaks you. The pain you feel can be a gift in disguise. It can be a path, leading you towards others just like you. It can be the fuel to inspire you to reach out your hand to others. Do not deprive the world of you. You are special. You are loved. And you are needed.

Patsy in conversation with Jerome

Jerome: Looking back do you think the source of your mental health problems originated in your childhood upbringing?

Patsy: I personally feel there were a number of factors at play. I am a very sensitive person; my mother describes me as a particularly fussy baby. I would argue that I had an increased propensity towards sensitivity, this coupled with a history of mental health issues within my family and the tumultuous, volatile family environment created the perfect conditions to develop a mental health condition.
Jerome: You mentioned that the turnaround in your mental state came from spirituality. What part does spirituality play in your life these days?

Patsy: For me, spirituality plays a key role in my day-to-day wellbeing. I meditate most days, and I have a strong belief in a higher power. For me, the sense that I am being guided and supported by something greater than I am provides me not only the strength to continue, but the faith that improvement will come and the reassurance that any suffering will be for a higher purpose.

Jerome: While you say suicide was something you contemplated as a child, you made a very serious attempt at 21. What keeps you going nowadays?

Patsy: My daughter without doubt keeps me going. I still have bad days with my anxiety in particular. However, knowing I have a little person watching me, relying entirely on me, modelling herself on the behaviours I demonstrate gives me a reason to hold on in those days. I also feel I am much more prepared for those bad days. I know they will pass, that it is acceptable to take time if I need it and that I have fought my way through before.

Jerome: Reading was for you a way to escape from a troubled childhood. You are now writing children’s books to help them understand and cope with themes such as grief and meditation. Would such books have helped you?

Patsy: I feel that certain books, although not implicitly about mental health, hold metaphors and overlap relating to mental health, and for me those books were my escape. I also find with my own daughter, we have such an open dialogue, and I talk candidly to her about mental health, and she shares her “worries” with me. For some children, there will be no conversations or acknowledgement that it is ok to be different or struggling or scared. I think to use books is a really accessible, simple way to open the dialogue between parents, teachers and children. In that regard, I think it may have been a real asset to me in my own childhood. I was extremely shy and would never have volunteered information regarding my feelings or concerns without prompting in some way. I am sure that applies to many other children.

Jerome: What does the concept of hope mean for you?

Patsy: The word hope actually makes me quite emotional. For people suffering with mental health issues you start out with this notion of recovery as a destination. When you begin the journey towards recovery, however, you realise that recovery is a continuing road which you will need to walk down indefinitely. Hope does not look like happiness like you expect. Hope is simply a sense of calm and peace amidst the chaos. It is the days you never thought you would see, and the belief that although you would not leave this road, maybe there will be some beautiful things along this journey that you would not find anywhere else.

Jerome: What changes would you most like to see in mental health services?

Patsy: I would love to see mental health and wellbeing being discussed with children in schools. I would love to see employers and teachers and the wider society adopt a more understanding approach. I would love for mental wellbeing to rank higher in importance than money, profit, productivity and “soldiering” on. I think mental health services are doing all they can do. The issue is the attitudes held by the wider society in respect of mental health conditions. For many people the issue is taboo, uncomfortable and often ignored as a result. That needs to change before any significant improvements can be made.

Jerome: What are your views on the use of medication for mental health problems?

Patsy: Whilst I can see the benefits for medication in relation to some mental health issues, I personally think medication alone is like putting a plaster on a leaking swimming pool. There are often deeper issues that need dealing with.

Jerome: How do you think mental health services can best help promote recovery, which is said to be the goal of many services?

Patsy: I think recovery should centre first on being completely honest with yourself and others. Stop running from the reality. I think it is extremely important to experience the emotions and pain within yourself, acknowledge their presence, but do not wallow there. I think it is then necessary to identify triggers, make appropriate changes in your lifestyle and to have a clear plan to keep on
track with these changes. I think it is then time to start seeking out small joyful moments and experiences. Whether that is a nice meal, a good book to read or a trip with friends. For mental health recovery services, I feel the role is to be a friend, a mentor, a guide and a support through each of these stages. To listen, but also to gently push and motivate and to encourage. Ultimately, however, recovery is a journey that only you can walk.

Jerome: Have you been inspired by any mental health or healthcare professionals you have come across?

Patsy: My inspiration comes from other individuals who have suffered mental illness and thrived despite it all. In complete honesty, the mental health professionals I have encountered during my journey seemed overwhelmed and there was no follow-up after I stopped attending appointments without notice; however, this was some years back and I am sure not a reflection of current service standards.

Jerome: In terms of people with lived experience of mental health problems, have any specific individuals impressed you?

Patsy: There are so many inspiring advocates of mental health currently, which is wonderful. Personally, my absolute all time hero is JK Rowling. Most likely because I relate so strongly to the notion of being a depressed single mother with nothing but books to keep her going! But furthermore, I feel that she signifies to me that big dreams are still achievable, even after hitting rock bottom.

Jerome: What challenges lie ahead for you? What do you most want to achieve in the future?

Patsy: My biggest challenge is myself. I self-sabotage when my anxiety is high. My ultimate ambition is to have my books published, to spark conversations for children who are suffering and to see not a decline in mental health issues, but simply an understanding that difference can be equally beautiful as it is chaotic. There is creativity and empathy to be found in suffering.

Jerome: What would you most like to be remembered for?

Patsy: I want to be remembered as an amazing mother, a supportive loyal friend and a voice for children. I want in years to come a person somewhere to say “Those books saved me”.

Conclusions

Patsy sees parallels between the life of JK Rowling and herself. Both single parents. Both having experienced depression. Both writers. The transformation in JK Rowling’s life following the success of the Harry Potter novels is probably unique. Perhaps more than anything, each of us as human beings wants to know that we have had some impact on life. As a workshop attender once explained to me, “We are born, we die, it’s what we do in between that matters”. Patsy’s hope is that her children’s books, through their focus on painful issues, may help save others from the suffering that accompanies mental distress. I hope so too.

About the authors

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Mediating effect of online social support on the relationship between stress and mental well-being

Naveenraj Xavier and Reeves Wesley J.

Abstract
Purpose – Workplace stress is on the rise and progressive organizations devise their own mechanisms to mitigate it and enhance mental wellbeing (MWB). Of late, the workforce is increasingly dependent on social networking sites (SNS) for social exchanges and debate is well documented if SNS could be used to mediate the relationship between stress and MWB. The purpose of this paper is to investigate this relationship.

Design/methodology/approach – This study is based on a survey of 269 employees, on the following constructs: stress, online social support (OSS) and MWB. The authors’ proposed framework was investigated using structural equation modeling.

Findings – Results indicated that stress has a significant negative effect on MWB and subsequently, OSS partially mediates the relationship between stress and MWB. The results suggest that organizations allow the use of social networking site in a controlled setting so that employees could use this as a mechanism to control stress and enhance MWB.

Originality/value – To the best of the authors’ knowledge, this is the first study on OSS role in mediating the relationship between stress and MWB.

Keywords Stress, Social networking sites, Mental wellbeing, Online social support

Paper type Research paper

Introduction

Work and family are the two most important roles an individual plays in life (Priyadharshini and Wesley, 2014) regardless of cultural and natural boundaries. Nonetheless individuals always identify themselves with work role as they provide identity and is considered to be the most common and valued, perhaps the only source of existential support. Workplace identities are core role identities that, for most individuals are salient and central aspect of self-concept. Accordingly, identity-relevant experiences in workplace are expected to manifest a healthy work environment where the demands, pressures and expectations are compatible with their abilities and resources. However, studies on workplace experiences suggest that workplace are a major source of stress. Studies on “Best place to work,” “Best employer” or “High performing workplace” indicate that organizations that provide a friendly environment are sparsely found. Accordingly, stress becomes an inevitable part of human life that affects the individual’s mental and physical wellbeing.

Stress is a much debated and researched topic in organizational behavior. It is viewed as an extremely personalized phenomenon and, hence, behavior that follows is believed to be different in similar situations (Naveenraj and Wesley, 2017). The difference in behavior may perhaps be the reason for inconclusive results in research on stress. Newer antecedents determined by the changing work environment vary stress levels and individuals use one or more than one coping mechanism (Chang and Lu, 2007; Vong et al., 2018).

Notably, social interactions or interpersonal exchanges with significant others is a pervasive mechanism individuals adopt to mitigate level of stress and its impact on mental wellbeing (MWB).
(Buwalda et al., 2005) and other stress-related factors such as work-family conflict (Rekhapershadharshini, 2015). With the widespread use of internet and exchanges in social networking sites (SNS) and SNS providing an alternate, easy-access and quick platform for social interactions or interpersonal exchanges, it is believed that individuals increasingly seek support on workplace issues from the host of members in SNS. Active participation in SNS is increasingly becoming part of their daily routine. The statistics published in an online portal (www.statista.com/statistics/433871/daily-social-media-usage-worldwide/, accessed July 5, 2018) revealed that approximately 2bn users use SNS and apps in 2015 and is likely to cross the 2.6m mark by 2018. Even developing countries such as India witness a 10 percent increase in SNS users each year. This may perhaps be, estimated to be the current generation’s progressive exchanges in SNS to build up new or retain old relationship proves this point. Such exchanges significantly provide space to increase social support and wellbeing (Smedema and McKenzie, 2010). A study on stress and MWB is essential as it is the determinant for many individual and organizational practices. In workplace several factors (job demand, available resource, organizations culture and peer group relationships) predict the employee’s MWB and have a major impact on individual’s performance (Xanthopoulou et al., 2009).

The aim of this paper is to study the relationship between stress and MWB and the mediating effect of online social support (OSS) on the relationship between stress and MWB.

Hypothesis development

**Stress and MWB**

Stress is a common phenomenon and plays multiple roles in the modern workplace. Hans Selye (1976) defines “stress as the non-specific response of the body to any demands made upon it.” Research reveals that several factors associated with job disturb the behavior and normal life of employees, thus causing stress (Newman and Beehr, 1979). Stress plays a positive role in increasing attentiveness and organization’s efficiency. On the other hand, an extreme level of stress can affect one’s health, productivity and approaches towards the organization (Demerouti et al., 2014; Smith et al., 2012) and therefore, individuals will not feel happy working in the organization. Individuals who face an excessive amount of stress often report one or more than one negative outcomes that include poor MWB (Tweed et al., 2004).

MWB is an increasingly significant and necessary concern in the modern workplace. Notably, wellbeing refers to personal happiness, feeling good and living safely and healthy. MWB in the workplace is one of the important concerns that continue to receive regular attention (Danna and Griffin, 1999). This means, not allowing work-related stress to affect MWB and, thus, weaken our basic purposes and needs in our lives, families and loved ones. In this respect, wellbeing is an immensely significant aspect of our work and careers. Stress has a foremost influence on employee’s MWB (Marzuki and Ishak, 2011). We hypothesize that MWB and stress at workplace are closely intertwined.

**H1.** Stress is negatively related to MWB.

**Mediating role of OSS**

Social support has been defined as “the resources provided by another person” (Cohen and Wills, 1985). It is considered as a supportive mechanism rooted in interpersonal interactions, which offers emotional comfort, instrumental support, information and appraisal (Cutrona et al., 1990) and it could provide a self-esteem, sense of belongings and nurturing behavior to buffer anxiety and depression (Berkman, 1985). It refers to how an individual is networked and influenced either directly or indirectly by another person (Cohen, 2004) and plays a vital role in maintaining people’s mental health, during stressful times (Albrecht and Adelman, 1984). It plays a major key to many human actions, including the successful management of stress. Social support that comes from the group member’s buffer against perceived stress (Frisch et al., 2014). Research found that social support acts as a communication process and influence the conflict between role stressors, inter-role conflict and wellbeing (Aryee et al., 1999; Tanis, 2007). Social or interpersonal exchanges with significant others are the dominant contributor to MWB
Newsom et al., 2008) and may shape the effects of stress. Several studies have stated that the simple fact of being in a supportive social network of family and friends could openly improve MWB (Finch and Vega, 2003; Uchino, 2006).

Of late, the internet has been used for interpersonal exchanges (Naveenraj and Wesley, 2017; Valkenburg and Peter, 2007). Certain studies have found that individuals experienced some affirmative psychological outcomes while using various SNS (Kim and Lee, 2011). The current generation employs SNS as a major source of emotional support (Chen and Shi, 2015). It is viewed that SNS endows individuals with the ability to begin new relationships and seeking interpersonal support that cannot be achieved in real life (Valenzuela et al., 2009). Moreover, the number of members in the individual’s network is on the rise. According to Eastin and LaRose (2005), SNS have a positive relation to the perception of social support. It could significantly reduce feelings of loneliness and depression, and significantly increase perceived social support (Shaw and Gant, 2002). Rozzell et al. (2014) examined that the perceived social support for internet users attained from close and non-close individuals, respectively.

Literature suggests that OSS groups or communities (for example, Crisis Chat, phpBB, Plush, PFLAG, CoSLAA, Alzheimer’s Association) are becoming widespread and it provides informational and emotional supports (Van Uden-Kraan et al., 2009). OSS groups are offered a virtual space where individuals can come together through internet to share their stories, life experiences and lives in a way that comforts people from isolation and loneliness. These kind of groups are open to anyone, but they are often motivated on specific topics (i.e. depression, family, work, grief, etc.) that that potentially enhances wellbeing (Smedema and McKenzie, 2010; Zheng, 2013).

SNS has gradually become integrated into everyday life, thus becoming a crucial medium for giving and receiving social support. Recent studies have established that people gain support from friends on Facebook to reduce stress and increase wellbeing (Jih-Hsin et al., 2016). Specifically, Facebook friends are connected with a better social support that reduces stress and enhances MWB (Robin et al., 2013). We hypothesize that OSS mediates the relationship between stress and MWB.

H2. OSS mediates the relationship between stress and MWB.

The framework indicating the relationship formulated in the hypothesis is diagrammatically represented in Figure 1.

Methodology

Participants

A questionnaire-based survey data were collected from IT employees in product-based IT companies in Chennai, India. The criteria for inclusion in this study were that the respondents should have experienced stress and should have been using the online medium in the workplace.
This was done to ensure that the respondents have a perceptible experience of stress and have taken support from members in SNS. Half of the questionnaires were administered in person and the remaining by choosing a contact person in the company. However, the respondents were either met or contacted over the phone later to solicit their kind cooperation in filling up the questionnaire. A thorough follow-up was done to expedite the process of filling up the questionnaire. Out of 350 questionnaires distributed, 269 were usable and complete yielding a response rate of 77 percent.

**Measurement Instruments**

The total number of items was 33.

**Stress**

One of the most extensively used tool for assessing the perception of stress is the Perceived Stress Scale (PSS) (Cohen et al., 1983). The original version of Cohen’s PSS consists of 14 items; however, it was later reduced to ten items, eliminating four items based on the results of principal component analysis. A ten-item PSS was used to measure and the scale is a reliable and valid instrument to measure stress in multiple contexts (Andreou et al., 2011; Ramírez and Hernández, 2007), e.g., “have you been upset because of something that happened unexpectedly?”, “have you felt nervous and ‘stressed’?”, “have you felt unable to control the important things in your life?”, “have your felt confident about your ability to handle personal problems?”, “have you felt that things were going your way?”, “have you found that you could not cope with all the things you had to do?”, “have you been able to control irritations in your life?”, “have you felt that you were on top of things?”, “have you been angry because of things that happened that were outside of your control?”, “have you felt that difficulties were piling up so high that you could not overcome them?”.

**Mental wellbeing**

MWB was measured using Warwick-Edinburgh Mental Wellbeing 14 item scale that relate to a person’s state of MWB (thoughts and feelings). Sample items include “I’ve had energy to spare,” “I’ve been dealing with problems well,” “I’ve been thinking clearly,” “I’ve been able to make up my own mind about things,” “I’ve been interested in new things,” “interested in other people,” “useful,” “relaxed,” “cheerful,” “good about myself,” “confident,” “loved,” “close to other people,” and “optimistic about the future.”

**Online social support**

OSS was measured using a 40-item Interpersonal Support Evaluation List scale. The 40 items were content validated using Lawshe’s formula and accordingly, nine items that scored 0.50 and above were included. Sample items are “There are several people that I trust to help solve my problems,” “When I feel stressed at workplace, there are several people on online I can talk to,” “There really is no one in online who can give me an objective view of how I’m handling my work problems,” “I often chat or talk with family or friends through online,” “There are several different people in online to motivate me,” “There is someone in online I can turn to for advice about handling problems with my coworkers,” “When I need suggestions on how to deal with a personal problem,” “I know someone in online I can turn to,” “There is someone in online I could turn to for advice about making career plans or changing my job,” and “There is atleast one person in online I know whose advice I really trust.”

OSS was measured using a five-point scale with 1 anchored for strongly disagree; 2 = disagree; 3 = neither disagree nor agree; 4 = agree and 5 = strongly agree. Stress and MWB were measured using a 5-point scale with 1 anchored for never; 2 = almost never, 3 = sometimes, 4 = fairly often, 5 = very often. α reliability coefficients of the scaled measures were computed to test the reliability of the instrument. The reliability coefficient for stress is 0.82, MWB is 0.87 and OSS is 0.86.
Results

The structural model is diagrammatically represented in Figure 1. The objective of this paper is to test the mediating effect of OSS on the relationship between Stress and MWB. The direct relationship between stress and MWB was tested in AMOS version 19 at the first step. The model fitness was established using $\chi^2/df = 1.54$ which is less than the guided value of 3. Other indices used to establish model fitness are Goodness-of-fit index (GFI) = 0.98 (> 0.90); Adjusted Goodness-of-fit index (AGFI) = 0.903 (> 0.80); Tucker–Lewis Index (TLI) = 0.921 (> 0.901); Comparative fit index (CFI) = 0.921 (> 0.90); RMR = 0.051 (< 0.08); RMSEA = 0.03 (< 0.08). These indices estimate the fitness of the model. The regression weight is presented in Table I. Results show that stress negatively influences MWB (estimate = −0.152; $p = 0.012$). $H1$ is supported.

The mediating effect of OSS on the relationship between stress and MWB is done at the second step. The model fitness was established using $\chi^2/df = 2.3$ which is less than the guided value of 3. Other indices used to establish model fitness are GFI = 0.91 (> 0.90); AGFI = 0.88 (> 0.80); = 0.91 (> 0.90); CFI = 0.901 (> 0.90); RMR = 0.06 (< 0.08); RMSEA = 0.03 (< 0.08). These indices estimate the fitness of the model.

Results show that all links stress → OSS, OSS → MWB and stress → MWB are significant. This indicates that OSS partially mediates the relationship between stress and MWB. Hence, $H2$ is partially supported (Table II and Figure 2).

Table I Showing the standardized regression weights

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<th>Description</th>
<th>Estimate</th>
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<tr>
<td>MWB ← Stress</td>
<td>−0.152*</td>
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Note: *Significant at 0.05 level

Table II Showing standardized regression weights

<table>
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<tr>
<th>Description</th>
<th>Estimate</th>
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</thead>
<tbody>
<tr>
<td>OSS ← Stress</td>
<td>0.189*</td>
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<tr>
<td>MWB ← Stress</td>
<td>−0.194*</td>
</tr>
<tr>
<td>MWB ← OSS</td>
<td>0.219*</td>
</tr>
</tbody>
</table>

Note: *Significant at 0.05 level

Figure 2 Standardized estimates of the final model
Conclusion

Discussion and implication

In summary, this study was first of its kind establishing the mediated relationship between stress and MWB by OSS. Table I shows that H1 is supported. This is consistent with the results of Robin et al. (2013) and Babajide and Akintayo (2011). This suggests that stress is a pervasive organization-specific phenomenon negatively predicting MWB. Organizations are cognizant of this and, hence, formulate policies to control the relationship, though, completely bringing it under its purview may require a strong arm. This suggests that stress and its impact on MWB could be partially controlled. Notably, this has been supported by the mediating results wherein, OSS partially mediates the relationship between stress and MWB ruling out complete rescind. Partial mediation suggests that stressed individuals seek increased social support online to, atleast partially obliterate stress and its effect on MWB. In order to access to social support online and realize this daunting task, SNS is used as coping platform. This is supported by H2. This result is partially or completely consistent with Luger et al. (2009), Manja et al. (2011) and Wimberly et al. (2008). This study is unique as earlier researchers used social support as a mediator whereas we have used OSS as a mediator. Stressed individuals in organizations frequently use SNS seeking OSS and report higher MWB and lower stress. They are believed to be social sharing both positive and negative organizational events associated with MWB and tend to share their stressful experiences with a wider range of people. This is believed to be a coping mechanism documented by a Pew Research reports that social media users tend to report higher levels of social support. It could be that seeking support in SNS leads to higher levels of social support, which in turn reduces stress and subsequently enhances MWB that often accompany stress. The findings of this study solidify the belief that individuals who are stressed in the workplace could use online SNS to mitigate the effect of stress on MWB.

This outcome recommends exactly how important it is for organizations to allow employees to use SNS that offer necessary support to enhance the overall wellbeing of an employee. Some organizations may allow workforce to access and use their personal online platform (Facebook, LinkedIn, YouTube, twitter, MySpace, etc.) in the workplace during work hours or break times. Other organizations might develop their own, internal online platform (for example, IBM has developed internal SNS (Beehive), Deloitte has created an internal SNS called D street and HP has developed its own internal SNS called Water cooler) to support employees work collaboratively irrespective of their physical location. Some organizations now offer online support groups, Listservs, discussion boards, blogs, Chat rooms and online communities as additional ways to connect with others in similar situations. However, the use of SNS in the organizations increases privacy implications for both employers and employees and, hence, to regulate the SNS use in the workplace, organizations should implement policies on the appropriate use of SNS in the work environment. When implementing SNS policies, it is significant to reflect the needs, happiness and welfare of individuals. These policies help to educate employees what is and is not acceptable SNS use. By letting SNS as a privilege and benefit, employers might have better employees. It is promising to allow SNS at workplace that pleases both the individuals and organizations. This was also emphasized conceptually by Naveenraj and Wesley (2017).

Furthermore, use of SNS is also widespread among current generations workforce for varied reasons, such as physical and emotional accessibility, constant availability, cultural diversity and overcoming language barriers. Risks and concerns are involved in the use of SNS in organizations, nevertheless, online exchanges enhance working relationships, open communication and create a supportive environment that reduces stress and improve wellbeing. This result is also more pertinent to organizations that employ more from Gen Y and it is well supported that this generation has more dependency on SNS.

Limitations

This study is not devoid of limitations. First, an overall measure of the scale was used to capture stress. Future researchers could measure stress as a three-dimensional construct that includes stimulus-based, response-based, stressor-strain based and, thus, the influence of three...
dimensions on MWB may be established. Second, data were collected from the employees in product-based IT companies. Future research may be done with employees in service-based companies and furthermore, invariance testing may be done on the results produced in the two sectors. Third, this study was done in the Indian setting and, hence, the scales borrowed from other studies may limit the generalizability of the scales. Future researchers could standardize the scales specific to this framework by running exploratory factor analysis and confirmatory factor analysis. Fourth, not always the OSS could explain the relationship between stress and MWB. It is expected that moderators could also determine the relationship between stress and MWB. Future researchers may use sex, income, age, occupational status, etc., as moderators along with OSS as mediators. Fifth, this study did not capture the age or gender differences in seeking OSS to mediate the relationship between stress and MWB and, hence, future researchers may capture this difference.

References


Further reading


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The process of establishing Discovery College in Melbourne

Liza Hopkins, Andrew Foster and Lara Nikitin

Abstract

Purpose – The purpose of this paper is to understand and inform the development and implementation of a newly established Discovery College (a youth-focused Recovery College). It also aims to contribute to a broader understanding of the benefits and barriers to establishing Recovery Colleges.

Design/methodology/approach – The overall study took a mixed-methods approach to the evaluation of Discovery College, including a qualitative process evaluation component as well as a mixed-methods outcomes evaluation. This paper reports on the findings of the process evaluation, which undertook key informant interviews with a range of stakeholders in the implementation process.

Findings – A total of 16 themes emerged from the qualitative data, which were then clustered into four main areas: establishing Discovery College, organisational context, nature of Discovery College and service transformation. Implementation was reported as both feasible and effective. Initial tension between fidelity to the model and a pragmatic approach to action was negotiated during implementation and through an ability of staff to tolerate uncertainty, enabled by the efforts and support of senior service management and college staff.

Originality/value – Recovery Colleges co-designed and implemented in youth mental health services are a recent development in the field of mental health care and very little has previously been published regarding the feasibility, effectiveness and acceptability of youth-focused Recovery Colleges. This paper is one of the first to assess the barriers and enablers to the implementation of Discovery College within a clinical youth mental health service.

Keywords Mental health, Recovery, Youth, Discovery College

Paper type Research paper

Introduction

In recent decades, recovery has taken a prominent position within the field of mental health. In this sense, the term recovery is defined as an ongoing, personal journey, experienced and worked towards by the individual with mental illness (Slade et al., 2014; Ralph and Corrigan, 2005, Perkins et al., 2012; Fortune et al., 2015). Driven largely by users of mental health services requesting more information, control and choice regarding illness management, this redefining of recovery has seen a shift in mental health policies and services from a “symptom-illness-treatment” type medical model towards one which aims to empower individuals through recovery and the promotion of subjective and functional wellbeing (Meddings et al., 2015; Slade, 2013; Zucchelli and Skinner, 2013). A large body of research highlights peer support and the sharing of lived experiences to be greatly beneficial to recovery (Repper and Carter, 2011; van Gestel-Timmermans et al., 2012; Hall et al., 2016; Meddings et al., 2014; Burhouse et al., 2015; Gill, 2014; Newman-Taylor et al., 2016; Zabel et al., 2016). In the area of mental health, the valuing of lived experience has provided unique insight into mental illness, as well as providing pathways to empowerment and self-confidence for those sharing their experiences (Stratford et al., 2016). Within this perspective, individuals with lived experiences of mental illness are acknowledged as experts and can provide valuable, insightful guidance, support and direction for mental health initiatives and services (Stratford et al., 2016).
Research consistently shows the incorporation of such practices into mental health initiatives and recovery programmes to be both effective and valued by individuals throughout their recovery journey (Repper and Carter, 2011; Meddings et al., 2015). Examples of this lie within Recovery Colleges that operate on recovery principles, utilising an educational model which offers a curriculum developed and delivered in collaboration by mental health professionals, educational professionals and people with lived experience of mental illness (Zucchelli and Skinner, 2013).

This study was conducted in order to inform the development and implementation of the South East Melbourne headspace Youth Early Psychosis Program (hYEPP) Discovery College (a youth-focused Recovery College), whilst contributing to broader understandings of the benefits of Discovery/Recovery Colleges for both young people and adults experiencing mental distress, the benefits for services and professional mental health providers and the practical barriers and enablers to developing such services.

The project was approved by the Human Research Ethics Committee of Alfred Health, the lead agency for South East Melbourne hYEPP (project no. 120/16).

**Context**

The aim of establishing Recovery Colleges is twofold. First to provide support to people with mental health challenges from an educational, rather than a strictly medical or therapeutic model. Key to this model is empowering individuals to become experts in their own care, supporting skill development and goal achievement and to provide opportunities for people to discover their potential and talents (Perkins et al., 2012, p. 2). The second aim is to shift the culture of mental health services from a traditionally medical model approach with a power dynamic based on professional expert/patient, to one based on a relationship where the professional and the service user are clearly on a more equal footing, both in terms of facilitating learning and as participants in the learning process (Meddings et al., 2015).

Recovery Colleges offer highly innovative and non-traditional approaches (Perkins et al., 2012), which reflect a significant shift in service orientation and models of care. This educational model emphasises an effort to work towards individual’s goals, strengths and rights, rather than being bound by diagnosis and treatment frameworks (Zucchelli and Skinner, 2013). In practice, removing the clinical mindset and responsibilities has proved to be a major success; students who are treated as “self-determined, responsible adults” respond positively to the college environment and are often liberated by this experience (Zucchelli and Skinner, 2013, p. 185). Courses aim to help empower individuals to develop their own coping mechanisms, goals and aspirations and become experts in supporting their own care (Meddings et al., 2015). They also look to bring people together, to connect with other people and organisations within their community and to build stronger, more resilient community-based relationships and partnerships.

**From Recovery to Discovery**

In 2014, a new hYEPP service was established in South East Melbourne. From the outset the values of the service included working in partnership with young people and families to create innovative services that were driven by young people’s needs. The leadership team were aware of the developing evidence base for the effectiveness of Recovery Colleges and recognised how this model could fit with their values and aspirations for the hYEPP service. In keeping with these values, the first step in establishment was to facilitate a workshop bringing together young people, families, friends, clinicians, managers and community members to consider whether this model would be the best for the needs of the community and if so what adaptations would be required. The concept of the Recovery College was received positively from all stakeholders, and so the youth-focused “Discovery College” was born.

Early in 2015, a learning consultant was recruited to ensure that learning principles were embedded in the college from initiation. A working group was formed to enable co-production of the establishment of the college as much as possible and smaller co-production teams were
developed to co-produce the first courses. Relationships and mentoring from other Australian Recovery Colleges were a key part of this stage.

The initial co-production teams, which consisted of a mixture of mental health professionals, young people using the service and lived experience professionals from other organisations, formed the beginnings of the pool of “Recovery Educators”, which would be built upon as the College developed.

By early 2016, Discovery College had developed some key processes including a “Course Development Agreement” (which provided detail as to how recovery benchmarks could be met throughout the process) and a structure of payment for staff working as contractors within the College; and had co-produced three new courses which were launched in May 2016. The journey to Discovery College had begun. By the end of 2016, a dozen different courses had either been developed or delivered or were in co-production phase.

Method

The process evaluation of the establishment of Discovery College took place over the course of 2016, as the college was beginning to gain traction within the broader mental health service. The evaluators worked closely with Discovery College stakeholders in a range of roles including service managers and college staff to collect qualitative data regarding their experiences of establishing a brand new Discovery College within an existing (albeit quite new) clinical service focused on youth mental health. The majority of the data were collected through individual key informant interviews, although some data were supplied in the form of written answers to the interview questions rather than through face-to-face interviews, depending on the preference of the respondent. All respondents provided signed written consent to participate and have their data used in the research.

Project participants included current professional staff employed by Discovery College, previously employed staff, lived experience facilitators and service managers. In total, 12 respondents completed either an interview (n = 10) or provided written responses to the interview questions (n = 2). The interviews ranged in length from 20 to 70 min and took place either in the participants’ workplace (n = 8) or by telephone (n = 2). Respondents were verbally thanked but not remunerated for their time.

The interview data were audio-recorded and transcribed verbatim before being analysed thematically using QSR’s NVivo 10 software package. The initial coding of the data resulted in the development of nine high-level codes which correspond approximately to the main themes of the questions in the interview schedule. These high-level codes were then coded a second time into 35 sub-codes using a grounded theory approach to incorporate emergent themes alongside the expected themes already identified.

Results

The coded data were then further analysed and 16 main themes were uncovered from the coded data. These themes were clustered into four groups which relate to the nature and process of establishing a Recovery College within a youth clinical service. The main themes and their clusters are presented in Table I.

Each cluster of themes reveals an aspect of the process of establishing the Discovery College which influenced the implementation process.

Establishing Discovery College

Establishing Discovery College within the context of a relatively new clinical service was a challenging process, with participants reporting a range of issues which influenced the speed and smoothness of programme development, along with a range of rewarding and revealing
moments and events. In particular, three main themes relating to the establishment of the college could be discerned:

1. the difficulties of establishing a skilled, trained and reliable peer workforce;
2. barriers to change such as access to learning spaces and logistics; and
3. the compromises required between fidelity to the Discovery College model and the pragmatics of establishing action.

The development of a peer workforce was identified by many respondents as a key task in establishing Discovery College. One participant noted:

We didn’t know at the beginning if all of the people who facilitated the courses needed to be young people. We realised quite early on that that was probably going to be impossible for a lot of different reasons.

In addition, the tension between fidelity to the theoretical model of Recovery Colleges and the pragmatics of establishing such a model was one of the most frequently remarked aspects of the establishment phase. These philosophical differences, described by one staff member as “intellectual tensions”, were seen to have delayed implementation as a senior manager describes:

[… there’s quite a few philosophical differences that’ve delayed things getting going and that whole idea that you had to be pure to the model versus pragmatic in getting things […] going.

Organisational context

Almost all the participants in the evaluation commented on the importance of the organisational context within which the Discovery College was being established. In part, the broader political momentum occurring around the recovery movement and the incorporation of recovery principles into strategic documents such as the National Mental Health Plan (Department of Health, 2016) paved the way for management to be able to support and resource the Discovery College. Managers interviewed for this evaluation commented on the importance of choosing to dedicate funds specifically towards Discovery College, whilst also noting that it is: “an incredibly, unbelievably efficient system. In terms of cost”.

In addition, having a champion to drive the Discovery College agenda was noted by some staff members as a critical feature in developing momentum:

I would probably pick out, you need that over-arching, that champion type person. You really need the backbone and I think we can see, we’ve noticed a difference since having [name]. We had a bit

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<td>Establishing Discovery College</td>
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<td>Champions</td>
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of brief period where we didn’t have that person as such. I think since we’ve had that person who’s passionate and sitting behind it, helping out with absolutely every aspect of it. There’s been a huge difference.

The nature of Discovery College

The requirement for co-production and co-reception of courses between experts with a lived experience and experts by profession or training is a critical component in distinguishing Discovery College from both other clinical services and other educational offerings. Significant features of Discovery College can be grouped into those which relate to the nature of the course production and delivery (co-production, co-reception, mutual respect and redressing power imbalances) and the learning which results from participation (both for staff and students) including increased understanding of subject area taught (such as self-harm or medication) and self-discovery or personal development through learning skills such as confidence and self-awareness. In addition, the role and importance of the concept of hope was raised by participants across numerous different roles, while the role and place of families in the Discovery College came up as an area still needing more specialised work.

Typical comments about the features of Discovery College which relate to the nature of course development and delivery include:

[…] the fact of the co-design element and the co-produce and the co-audience is.. it doesn’t, it sounds like a bit of a no-brainer but it’s sort of quite revolutionary. Normally, when I went through training, I just got lectures from experts about how to do something. This is a totally different way of education for mental health.

And:

[…] too often, I, I see especially people putting a lot of, there’s a lot of weight, I think, put on people who have professional backgrounds, be that the doctor or the, um, the psychologist, or the psychiatrist. And, um, I think while their input is invaluable, it doesn’t tell the whole story. And I think that the important, that the, one of the most important things, if not the most important thing about the Discovery College is that it’s, the courses are created with a combination and collaboration of those two aspects together. To sort of explain why that’s important, I know a lot of people, myself included, who would say to their, to their psychiatrist things like, well, you know, I, I really trust that you know a lot about medications and you understand all this stuff […] about side effects, and you know what dosage to use, and you listen to me very well, and you’re very empathetic. But you just don’t understand what it, what it’s like to be bipolar. And I hear that quite a bit.

Service transformation

One of the key components of the Discovery College as articulated in both the literature and the findings of this evaluation is that a siloed approach is to be avoided, and the essential features of Discovery College, as just discussed, need to inform the development of the clinical service more broadly. Recovery elements such as co-production and co-reception, mutual respect, reducing power imbalances and instilling hope are elements of the Discovery College which it is hoped will make their way into all aspects of the clinical service, transforming the way in which other elements of care are delivered and received. Service managers, in particular, were eager for the Discovery College courses to be well attended by professional staff, both to support the co-reception model of the college and to inform professional development and re-orient clinical staff thinking and practice. One senior service manager described the legitimation of lived experience expertise:

I think it enhances the culture by having the people using the service being really part of the service, it’s gonna improve your culture I think. On a number of different levels – not on just a symbolic level, but actually, you know, I know with these workshops we did, we got great ideas. […] I think you learn a lot about what helps by going through something. So, it’s a legitimate expertise, so having that in [the broader service] also improves the culture just from a knowledge perspective.
Discussion

This project has demonstrated that Recovery Colleges can have a major part to play within and alongside mental health services, both from the perspective of supporting individuals to determine and direct their own journeys of recovery and also in supporting services to transform the way in which they engage and interact with those who use them. It has revealed that setting up a youth-focused Recovery College throws up similar challenges to doing so in an adult space. Whilst a clear and distinct set of guiding principles for Recovery Colleges exists (e.g. Perkins et al., 2012), the reality is that absolute fidelity to the model is not always possible, nor indeed, essential or even desirable in a different context. For example, whilst it may in some circumstances be desirable to locate the college in its own physical space or building (“the campus”) away from treatment spaces, having yet another physical location to which young people must find their way may in some cases be a deterrent rather than an enhancement, as well as potentially contributing to the college being siloed from other parts of the service. Through taking a “trial and error” approach we have identified a set of themes or implementation issues which need to be considered in any future iteration of the Discovery College.

Perhaps the biggest new learning (and highly significant in the field of youth-focused Recovery Colleges) is that whilst there is value in having a portion of the peer/lived experience workforce that is “youth” in age, the reality is that that may not be feasible at the outset. Having a workforce of people who can draw on a lived experience in a way that is meaningful to youth, however, is both possible and appropriate. Much of the valuable work undertaken at Discovery College has come through close collaboration with people who either experienced mental health challenges as young people and can ably reflect back on that or those who as adults can share their stories in ways that engage the youth audience. Nonetheless, there is a strong acknowledgement of the importance of engaging youth as part of the team of “Recovery Educators” where possible, both from the perspective of hearing the youth voice and as a way of helping those individuals to take further control in their own life journeys.

Conclusion

The establishment of Discovery College in Melbourne was an iterative process of trial and error, combining a commitment to model fidelity with a real-world pragmatism that allowed experimentation and actual progress from theory to action. While always underpinned by an uncompromising view that co-production and co-reception of courses was core to the whole enterprise, the establishment of the college required a degree of negotiation and flexibility in the early stages, building a competent and confident workforce of both experts by profession and experts by experience based in what had been a purely clinical youth mental health service.

The process evaluation of Discovery College has demonstrated that the establishment of such a programme within a clinical service is both feasible and effective; however, significant issues must be addressed if the college is to succeed. Careful consideration of issues such as workforce training and support, commitment to co-reception as well as co-production and service transformation through the incorporation of recovery principles across the entire service, not merely as an “add on” offering, are critical to the success of the undertaking. The support of service management and provision of adequate resources are also essential elements of satisfactory implementation.

Currently, many mental health services are embarking on a transformative process, with a shift from seeing clinical staff as the “experts” in a hierarchical power-based dynamic, to “[...] support(ing) people in whatever way they personally find most helpful. Sometimes this is referred to as ‘services on tap, not on top’” (Cooke, 2014, p. 72). As such, much of this “new” way of operating requires a will and an ability for professionals working in services to be able to sit more easily with the unknown, to be comfortable in not having all the answers. Establishing Discovery College has illustrated the importance of such a philosophy as much of the most valuable learning in this process has come from simply trying things...
and being open to what might be discovered. It is our hope that this rich knowledge and learning will be of benefit to others as they embark on establishing their own youth-focused Recovery Colleges.

References


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Educational outcomes of Discovery College participation for young people

Liza Hopkins, Glenda Pedwell and Stuart Lee

Abstract

Purpose – The purpose of this paper is to understand why young people and adults enrolled in co-produced, co-received Discovery College (a youth-focused Recovery College) courses, what their experience of participating was, and whether attitudes towards education changed as a result of course participation.

Design/methodology/approach – The study used a pre- and post-participation survey to assess both the qualitative experience of participants in Discovery College courses, along with a quantitative component measuring change in attitudes to education and learning opportunities.

Findings – The project found that participating in Discovery College benefitted young people through: an improved attitude towards education; and greater likelihood of participating in future study after completing a Discovery College course. People who participated in Discovery College courses, both young people and adults were positive about their experiences with the college and experienced positive attitude change. This work demonstrates the importance of Discovery College as part of a holistic approach to the care of young people with mental illness.

Originality/value – This paper reports on one of the first evaluations of youth-focused Recovery Colleges globally. It provides evidence of the effectiveness of the Recovery College model for a youth cohort.

Keywords Mental health, Recovery, Youth, Discovery College

Paper type Research paper

Introduction

The rise of the recovery focus in mental health has seen a rapid, recent shift in some mental health services (Slade et al., 2014; Warner, 2009). Evidence of this shift may be seen in the development of Recovery Colleges, which offer participants an opportunity to come together as both providers and consumers of mental health services, learning collaboratively and focussing on each individual’s personal strengths, interests and hopes (Burhouse et al., 2015). Key defining features of the Recovery College approach include the way in which all aspects of each course are co-produced and co-delivered by people with lived experience of mental illness working together as equals with mental health and education professionals (Perkins et al., 2012; McGregor et al., 2014). Courses in Recovery Colleges are usually designed to improve knowledge of mental health experiences and increase self-awareness, enabling students to improve their own self-management. Courses are all designed to be co-received, with mental health consumers, family members and professional staff coming together to learn new perspectives, in which one way of knowing is not privileged over other ways. Developing and implementing Recovery Colleges in existing mental health services offers an opportunity to re-orient clinical services to have more of a recovery focus.

As Recovery Colleges are relatively new, published research is currently limited (McGregor et al., 2014). Available evidence suggests that their establishment can be beneficial in promoting the recovery journey of individuals and the recovery orientation of mental health services implementing them (Perkins et al., 2012). Student feedback from participants has been reported to be positive (Meddings et al., 2015). Personal recovery gains were also reported by students which included feeling better able to control their own recovery and improved confidence and self-esteem.
A recent interview study with Recovery College students identified an overarching theme of “connecting with others differently” that was reported to underpin how college participation facilitated attitudinal and behavioural change (Newman-Taylor et al., 2016). The ability to co-produce courses was a learning opportunity but also provided inspiration and an opportunity to gain confidence and make personal development plans.

Very little is known about the effectiveness of Recovery Colleges for young people, despite the high prevalence of mental distress in young people and the fact that mental illness often manifests for the first time in this age group. This paper reports on the findings of an evaluation of a recently established Discovery College in Melbourne, Australia. The name Discovery College reflects the youth focus of this Recovery College model.

The evaluation included both a process component and an outcomes component. We describe elsewhere the process of establishing a youth-focused Discovery College within an existing clinical service (Hopkins et al., forthcoming) and detail the college co-production, co-reception model, as well as discussing the barriers and facilitators to establishing such a new model of service. This current paper aims to explore the reasons why young people and adults enrolled in Discovery College courses, what their experience of participation was, and whether attitude towards education changed as a result of course participation.

Method

Design

This study was conducted between June 2016 and March 2017. It involved the use of an online survey completed prior to and following course participation to capture why students participated, attitudes to learning both before and after participation in the Discovery College, and how the course was experienced. Items examining attitude towards education were asked both prior to and following course participation to enable comparison of change in attitude over time.

Participants

Participation in the survey was open to anyone enrolled in a course, both young people and adults. For the purposes of analysis, young people’s responses were separated from adults’ responses in order to understand if experiences of the two cohorts differed. Young people participating in Discovery College were predominantly users of mental health services whilst adult participants were predominantly staff of mental health services. Adult participants also included parents of young people and tertiary students on placement with the mental health service.

During the study period a total of nine Discovery College courses were conducted. During this time, 141 individuals participated in at least one course. This included 84 young people (46 female; 38 male) and 57 adults (44 female; 13 male). In total, 65 participants completed a pre-course questionnaire and their demographics are shown in Table I.

Measures and procedure

The project was approved by the Human Research Ethics Committee of Alfred Health [No. 120/16]. All respondents provided signed written consent to participate and have their data used in the research. The web-based survey tool Redcap[1] was used to deliver the survey. The Pre-Discovery College Student Survey collected data regarding the participants’ age, gender, level of schooling completed, whether they were currently studying and employment status. The pre-survey also asked for reason for enrolment and open-ended responses to six questions:

1. What do you hope to learn in this course?
2. What are you looking forward to about the Discovery College?
3. What do you think will be different about Discovery College compared to other experiences you have had with mental health services?
4. What will help you get the most out of this course?
5. What things might stop you from getting the most out of this course?

6. Is there anything else you would like to tell us about Discovery College?

Eight questions were asked on both the pre- and post-group survey assessing attitudes towards education (items are shown in Table II). Responses were rated on a five-point Likert scale (strongly disagree–strongly agree).

In addition, the post-course survey asked six questions regarding the participants’ experience in the course:

1. Did you learn anything new in your Discovery College course?
2. What was the best thing you learned about in this course?
3. Was there anything you didn’t like learning about?
4. What things made it easy to learn at Discovery College?
5. Did anything make it hard for you to learn at Discovery College?
6. What could be done better next time?

Table I  Demographics for students who completed a survey

<table>
<thead>
<tr>
<th>Variable</th>
<th>Youth students (n = 36)</th>
<th>Adult students (n = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>17 (47)</td>
<td>7 (24)</td>
</tr>
<tr>
<td>Female</td>
<td>19 (53)</td>
<td>22 (76)</td>
</tr>
<tr>
<td>Highest education completed: n (%)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>9 (25)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Secondary school</td>
<td>12 (33)</td>
<td>1 (3)</td>
</tr>
<tr>
<td>TAFE/Apprenticeship/University</td>
<td>15 (42)</td>
<td>28 (97)</td>
</tr>
<tr>
<td>Currently studying elsewhere: n (%)</td>
<td>8 (22)</td>
<td>7 (24)</td>
</tr>
<tr>
<td>Where studying: n (%) of currently studying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secondary school</td>
<td>3 (38)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Technical and Further Education (TAFE)</td>
<td>0 (0)</td>
<td>1 (14)</td>
</tr>
<tr>
<td>University</td>
<td>5 (62)</td>
<td>6 (86)</td>
</tr>
<tr>
<td>Currently working: n (%)**</td>
<td>20 (56)</td>
<td>27 (93)</td>
</tr>
<tr>
<td>How working: n (%) of currently working</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer</td>
<td>1 (5)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>Casual</td>
<td>4 (20)</td>
<td>2 (7)</td>
</tr>
<tr>
<td>Part time</td>
<td>8 (40)</td>
<td>10 (37)</td>
</tr>
<tr>
<td>Full time</td>
<td>7 (35)</td>
<td>14 (52)</td>
</tr>
</tbody>
</table>

Notes: *p < 0.05; **p < 0.01

Table II  Mean responses to items assessing attitude towards education

<table>
<thead>
<tr>
<th>Variable</th>
<th>Youth students (n = 22)</th>
<th>Adult students (n = 24)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-course Mean</td>
<td>Post-course Mean</td>
</tr>
<tr>
<td></td>
<td>(SD)</td>
<td>(SD)</td>
</tr>
<tr>
<td>Education is important to my future</td>
<td>4.36 (0.85)</td>
<td>4.59 (0.85)*</td>
</tr>
<tr>
<td>I like learning new things</td>
<td>4.73 (0.46)</td>
<td>4.92 (0.40)</td>
</tr>
<tr>
<td>I learn best when the course is relevant to me</td>
<td>4.57 (0.51)</td>
<td>4.62 (0.50)</td>
</tr>
<tr>
<td>I find it hard to concentrate for long periods</td>
<td>3.59 (1.10)</td>
<td>3.45 (1.14)</td>
</tr>
<tr>
<td>School is not for me</td>
<td>2.41 (1.05)</td>
<td>2.41 (1.05)</td>
</tr>
<tr>
<td>I want to study more in the future</td>
<td>4.05 (0.79)</td>
<td>4.27 (0.83)*</td>
</tr>
<tr>
<td>Getting a job is more important than going to school</td>
<td>3.18 (0.80)</td>
<td>3.09 (0.68)</td>
</tr>
<tr>
<td>My family support me to do my best in my education</td>
<td>4.38 (0.67)</td>
<td>4.24 (0.70)</td>
</tr>
</tbody>
</table>

Notes: n = 46. Assessed with the scale: 1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree; 5 = strongly agree. *These items were not completed by one youth student. **These items were not completed by one or two adult students. *p < 0.05
Analysis

To assess the change in items assessing attitude towards education from pre- to post-course, paired samples t-tests were conducted with an α of 0.05. In the event of missing data, analyses were only conducted with validly provided responses. Open-ended survey responses were thematically analysed using NVivo 10 software. The data were coded first using high level codes derived from the original research questions and survey guide questions. The coded data were then further analysed using a grounded theory approach (Charmaz, 2006) to elucidate the emergent concepts in the data. The coded data were then grouped into broad themes, aligning with the larger project qualitative interview data, which are reported elsewhere (Hopkins et al., forthcoming).

Results

Three aspects of collected survey data are presented. First is the experiential findings of the pre-course survey, which identifies the motivations, hopes and intentions of both adults and young people enrolling in a Discovery College course. Second is the post-course survey experiential data, which elucidate the experience of participating in a Discovery College course, including things which made it harder or easier to participate and what participants got out of attending. The third element is the change over time, which was collected through a series of Likert-scaled questions regarding attitudes to education, assessed pre- and post-participation.

Pre-course survey experiential findings

The pre-course survey indicated that youth (mostly service users) and adult (mostly mental health professionals) Discovery College course participants identified similar learning opportunities. In total, 19 young people (50 per cent) indicated their intention to participate in the course was to improve their knowledge of the course content. In addition 12 young people (32 per cent) hoped to increase their personal self-knowledge and understanding, while four (10 per cent) hoped to gain new perspectives on the course subject matter. Similarly, the majority of adults who enrolled did so with the hope of improving their knowledge of the course content (47 per cent), while 5 (17 per cent) hoped to increase their personal self-knowledge and four (13 per cent) hoped to gain new perspectives. Three adults (10 per cent) enrolled in a course with the hope of improving their understanding of how Discovery College works.

In regard to what they hoped to get out of the course, 19 (50 per cent) young people said they were looking forward to learning something new, while 12 (32 per cent) were looking forward to meeting new people. One young person was looking forward to having something to do.

In contrast, only four (13 per cent) adults said they were looking forward to learning new things, while 16 (53 per cent) said they were looking forward to the collaborative learning environment. In addition, 4 (13 per cent) adults said they were looking forward to learning about Discovery College.

Prior to attending a Discovery College course, youth participants suggested a range of factors which they thought could help them in getting the most out of their course. Speaking up \( (n = 7, \ 18 \text{ per cent}) \), a flexible learning environment \( (n = 3, \ 8 \text{ per cent}) \), a safe, respectful and supportive environment \( (n = 8, \ 21 \text{ per cent}) \) and engaging course content \( (n = 6, \ 16 \text{ per cent}) \) were the most common things identified as being helpful for young people. Similarly for adults, speaking up \( (n = 9, \ 30 \text{ per cent}) \), a safe, respectful and supportive environment \( (n = 6, \ 20 \text{ per cent}) \) and engaging course content \( (n = 2, \ 7 \text{ per cent}) \) were suggested as being helpful.

Things which were suggested as being likely to hinder young people’s participation were their emotional state (shyness, anxiety, negative mind frame) \( (n = 9, \ 24 \text{ per cent}) \), other students being disrespectful \( (n = 4, \ 11 \text{ per cent}) \), distraction \( (n = 5, \ 16 \text{ per cent}) \) and not attending or participating fully \( (n = 3, \ 8 \text{ per cent}) \). For adults the list of things which might hinder participation was similar. Fewer adults gave their emotional state as a hindrance \( (n = 3, \ 10 \text{ per cent}) \), but other students being disrespectful \( (n = 4, \ 13 \text{ per cent}) \), distraction \( (n = 3, \ 10 \text{ per cent}) \) and not attending or participating fully \( (n = 3, \ 10 \text{ per cent}) \) were rated similarly. Adults also listed having
competing work or time commitments as a potential barrier ($n = 3$, 10 per cent), being older than everybody else ($n = 1$) and rote learning ($n = 1$) as things which might stop them getting the most out of the course.

**Post-course survey experiential findings**

Of the 65 students with a pre-course survey completed, 46 also completed a post-course survey. Participants who did not complete both surveys ($n = 19$) did not differ significantly from those who did on gender ($p = 0.99$), age group ($p = 0.06$), currently working ($p = 0.29$), highest education level completed ($p = 0.06$) or currently studying elsewhere ($p = 0.80$).

All of the young people who responded reported that they had learnt something from the course. Typical comments included:

> I learnt a lot about how to deal with my own feelings and tools to help me deal with my mental health.

Adults also reported that they had learnt a range of things from the course, including new knowledge about others’ experiences, new insight into their own selves and more about Discovery College. Young people reported a range of things which they considered to be the best part of the course, including specific skills (“dealing with conflict”), self-empowerment (“That I should seek support if I’m ever feeling not well”) and acceptance (“Acceptance of myself and others”).

Adults also reported a range of things which they considered to be the best part of the course, including technical or professional skills (“How to open communication about self-harm”), self-discovery (“My values and what ones I hide”) and empathy (“Better understanding from the youth perspective and their difficulties in overcoming barriers”).

When asked if there was anything they did not like about the course, most young people said that there was nothing they did not like ($n = 15$, 55 per cent). Some negative experiences included:

> There was usually a lot of awkwardness when asking questions or sharing with the group but is to be expected from something like this.

> That it doesn’t offer specific ways to form an identity. I feel as though the day session was good but that additional sessions are needed to support what was discussed and implement strategies to form an identity (Self and identity course).

> I didn’t find the case study relevant to me.

Similarly, the majority of adults said there was nothing they did not like about the course ($n = 21$, 75 per cent). The few negative comments were quite minor:

> I thought the introduction to mindfulness could have been longer and included more discussion.

> More time for reflection/self-reflection during the day – leaving all the reflection for the end of the day was a bit tiring.

Things which made it easy for young people to learn at Discovery College were overwhelmingly the environment ($n = 16$, 60 per cent) and the people ($n = 7$, 26 per cent). Two young people (7 per cent) found the actual activities in the class helpful. One young person commented:

> Having a safe space makes it easier for me to learn and concentrate and reduces my anxiety. Discovery College does it well.

Adults also overwhelmingly identified the people ($n = 18$, 64 per cent) and the environment ($n = 6$, 21 per cent) as the factors which helped them to learn most. One commented:

> I really liked the collaborative nature of the course, not feeling like I was being “taught” but that we’re all learning together. This really allowed me to feel like everyone in the course had something to offer.

In total, 14 young people (52 per cent) reported that there was nothing which made it hard for them to participate in Discovery College courses. Two of those who did report difficulties described the risk of the course triggering a reaction:

> Perhaps outside factors on how I was feeling that day or certain topics I might find too personal might make it harder to participate in conversations.
The scenario given was much like my own which was really confronting and made my anxiety kick up and I started shaking but was able to overcome it.

Two others reported that concentration was an issue for them:

Personally I have trouble sitting still so I fidget a lot but other than that it was fairly easy once we got stuck into it.

The majority of adults also reported that nothing stopped them from participating \( (n = 19, \text{ 68 per cent}) \). Two reported missing classes due to being on leave, while two others reported that tiredness at the end of the day was an issue. One commented:

At times I had to stop myself from being a staff member rather than a participant.

While many young people reported that they could not think of anything to make the courses better \( (n = 9, \text{ 33 per cent}) \), others identified the need for more breaks \( (n = 1) \), more discussion \( (n = 2) \), course being shorter \( (n = 1) \) and course being longer \( (n = 1) \). A similar number of adults reported that they couldn’t think of anything to improve the course \( (n = 8, \text{ 29 per cent}) \), however, quite a few commented on the scheduling of the course during working hours as a potential barrier for those who are working \( (n = 6, \text{ 21 per cent}) \). Another wondered:

Whether it’s helpful for the mental health professionals in the room to have more opportunity to think about their role in supporting others.

**Change in attitude towards education**

Paired-samples t-tests conducted to compare attitudes towards study pre- and post-participation found that youth students rated two items significantly higher following course completion: “Education is important to my future” \( (p = 0.021) \); “I want to study more in the future” \( (p = 0.021) \). Adult students rated one item significantly lower following course completion: “I learn best when the course is relevant to me” \( (p = 0.043) \). These findings suggest that participation in Discovery College courses has a positive effect on young peoples’ attitudes and intention to study, while also influencing adults to reconsider pre-conceived notions of the importance of course content over participatory experience when learning in a co-production model.

**Discussion**

The current study was conducted to elucidate the experiences of young people and adults participating in Discovery College courses, and to contribute to the growing evidence base around the recovery focussed approach to mental health care. The study found that the knowledge, skills and empowerment gained from participating result as much from personal learning and the experience of co-production and co-reception as they do from the course content and specific learning goals.

Our findings have implications for the conduct of youth-focused Recovery Colleges through contributing to the growing evidence base. In particular, the adaptation of adult-focussed Recovery College into a more youth friendly, Discovery College model is feasible and effective. Young people, as much as adults, enjoy and are empowered by the co-production model of the Discovery College and are positively influenced in their thinking regarding age-appropriate participation such as returning to study or extending their education. Future work in this area may fruitfully be focussed on improving transition strategies for young people moving from Discovery College into mainstream education or vocational learning.

The findings of this study also highlight the significant effects of the co-reception model developed and implemented in Discovery College. The ongoing effects of staff and mental health professionals learning in the context of a course where young people are recognised as experts in their own lives, and power differentials between professional staff and clients are minimised or erased will likely result in transformation of service delivery in the host mental health service. The opportunity for professionals to learn from lived experience students and tutors can help challenge existing stigma or beliefs about recovery potential, build understanding and collaboration with young people and contribute to the service operating in a recovery-oriented manner (Perkins et al., 2012).
Limitations
A number of limitations were evident with this study. In particular, less than half of course participants completed a survey. In addition, the survey measured change in attitudes to education, however, in future iterations it could be expanded to capture change in attitudes to co-produced learning and shifts in personal attitudes and understandings of the mental health experience. The study also only focussed on immediate outcomes, due to the difficulties in tracing highly transient young people over time. It would be interesting to know if the results were sustained over medium- and longer-term periods.

Conclusion
People who participated in Discovery College courses, both young people (predominantly mental health service users) and adults (predominantly mental health professionals) were overwhelmingly positive about their experiences and offered both supportive and constructive comments to improve the service further. Benefits for adults included increased professional knowledge, improved empathy and enhanced self-knowledge. Benefits for young people included an improved attitude towards education and greater likelihood of participating in future study after completing a Discovery College course. Young people also reported better self-knowledge, better understanding of mental health and high satisfaction with their participation in the course. All the participants in the evaluation were positive about the changes brought to the service through the establishment of the Discovery College and were hopeful of future improvements, enhancements and expansion to enable greater participation in the college by a wider range of people.

Note
1. Study data were collected and managed using REDCap electronic data capture tools hosted at Alfred Health. Research Electronic Data Capture (REDCap) is a secure, web-based application designed to support data capture for research studies, providing an intuitive interface for validated data entry; audit trails for tracking data manipulation and export procedures; automated export procedures for seamless data downloads to common statistical packages; and procedures for importing data from external sources (Harris et al., 2009).

References


Further reading


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Exploring forensic environments: how do environmental factors influence individual outcomes for residents and staff? A systematic review

Karine Greenacre and Emma Palmer

Abstract

Purpose – Increasing attention is focusing on the role of environments in the rehabilitation of offenders, with a range of reported outcomes in the literature. The purpose of this paper is to explore forensic environments and the outcomes and changes that result, in order to assess the current knowledge in this area and to inform current and future practice.

Design/methodology/approach – Using a systematic review approach with an extensive literature search and robust application of appraisal methods, nine studies were identified. The studies included one mixed method study (n = 1), qualitative methods (n = 4) that utilised thematic analysis, interpretative phenomenological analysis and Foucauldian discourse analysis and quantitative methods (n = 4) that utilised the responses to psychometric measures including the EssenCES and correctional institution environment scale (CIES) to assess the quality and outcomes associated with environments in forensic settings.

Findings – Three superordinate themes were identified: factors required for successful environments, factors that influence successful environments and factors affected by successful environments.

Research limitations/implications – Further research would be beneficial around motivation, as it appears to influence the success of environments and be a potential outcome of environments. Further research might usefully explore the ideal time in services, for optimal outcomes in order to advise those currently commissioning services of this nature.

Originality/value – In addition to outcomes, this review found factors required for forensic environments that are consistent with previous literature within the field, and factors that might influence how successful environments can be.

Keywords Rehabilitation, Forensic, Enabling environment, Milieu, Therapeutic

Introduction

Background

Environmental factors in forensic settings are receiving increasing levels of attention to help understand custodial behaviour and contribute towards a rehabilitative agenda for offenders both within custody and after release. “Where” rehabilitation work occurs, for example, prisons, hospitals, etc., and the impact that it can have, is perhaps the least researched principle of models of rehabilitation that focus on “what works” and “how” (e.g. risk, need and responsivity model: Andrews et al., 1990; Andrews and Bonta, 2010). By examining “where” rehabilitation occurs, understanding the mechanisms at work and associated outcomes, we can contribute to the broader agenda of rehabilitation and risk reduction for offenders.

Research has identified a number of outcomes linked to modifiable factors within environments. In non-forensic settings, environmental distraction, e.g. noise, was found to link to individuals
making more extreme, stronger judgements about other people when they were exposed to noisy and distracting environments (when a more neutral judgement would be more appropriate) compared to individuals in quieter, less distracting environments (Siegel and Steele, 1980). Spreat et al. (1990) found that high noise levels suppressed the social interactions of patients with lower cognitive functioning. Baron (1990) found that participants exposed to positive stimuli (in this case, scent) set higher goals in a coding task and were more likely to adopt an efficient strategy for performing the task. Males also reported high self-efficacy, and set higher monetary goals and were more amenable during face-to-face negotiations. Finally, participants reported weaker preferences for handling future conflicts through avoidance and competition. Whilst not specifically focussed on forensic settings, it is reasonable to assume that there would be similar effects of environments within forensic settings.

In forensic settings, research shows similar links between setting conditions and outcomes. For example, Ryan and Deci (2000) highlighted that if the individuals’ experience of autonomy, competence and relatedness are unsupported in the social environment, there would be a detrimental impact on motivation and engagement in activities, such as performance, persistence and creativity. McNeill (2012) comments that harsh prison environments impact on the rehabilitative function of prisons.

In order to establish what contributes to environments being successful, it is important to consider the variety of aims of such environments. These typically include increased health and/or wellbeing and rehabilitation from a range of difficulties. Haigh (2013) describes these difficulties as resulting from problems in early life and deficits in primary emotional development. Haigh (2013) discussed five components: attachment, containment, communication, inclusion and agency, which are necessary for primary emotional development. He suggests the implementation of these components in a therapeutic environment can facilitate secondary emotional development. Secondary emotional development can help to tackle the previously highlighted difficulties (such as the aims mentioned above). Therefore, if the environment can offer the conditions that meet these emotional needs, the desired outcomes (e.g. positive shift in health and wellbeing) are achievable. This provides the underlying rationale for the conception of enabling environments (EEs) in the UK and the application of EE to prison rehabilitation.

A brief review of research exploring the five components described by Haigh (2013) follows to enhance the understanding of the links between these components and environmental outcomes.

**Attachment**

Attachment needs to happen in a culture where people feel like they belong, where attention is paid to the process by which individuals join and leave. Rollinson (2012) found that certain features of leadership ensure the continuity of a healthy therapeutic environment, such as ensuring that beginnings and endings for those within the environment receive attention. Taxman and Ainsworth (2009) highlight the importance of the correctional environment in delivering rehabilitative programmes and of directing efforts towards a milieu where therapeutic alliance and other positive relationships develop to achieve better outcomes. Factors that contribute to a positive therapeutic alliance include family involvement, collaboration and the creation of a non-blaming environment (Church, 2008). Some outcomes from positive relationships could include those summarised by Hearty et al. (2016) from two process evaluations that investigated the role that prison drug recovery wings[1] play in supporting recovery. The findings relating to attachment are the crucial nature of the relationships between prisoners and staff in building recovery capital; participants reported a more relaxed environment with less bullying. Other outcomes as a result of positive attachments include increased intrinsic motivation found by Gendreau et al. (2014), and the role that positive social environments play in supporting individuals to experience a shift in perspective regarding their confidence to cope and commitment to non-violence (Ellis and Bowen, 2017).

**Containment**

Containment is the safety of knowing what is and is not possible, achieved through the task of enforcing boundaries. Support systems are important in providing a way in which disturbance is tolerated and distress is held. Schalast et al. (2008) have proposed that the key characteristics of
a social climate in a forensic setting relate to the extent to which the perception of the climate as supportive of therapy and therapeutic change, whether mutual support is present and the level of tension and perceived threat of aggression and violence that exists. Rollinson (2012) linked the continuity that leadership provides, to similar findings. In relation to containment, this included emotional containment and “holding in mind”, “holding the line” and tolerating uncertainty.

**Communication**

In order for communication to be successful, then attachment and containment need to be in place securely, and safety is present in the atmosphere so that people experience some certainty that the community will accept and digest what they have to say. The defining characteristic is the expectation that communication is more open, profound and honest than happens in everyday situations. Psychologically informed planned environments (PIPEs) offer residents with complex needs such as personality disorder, a more contained, psychologically informed environment to support the progress made in prior interventions. Reports clinical observations that offenders who successfully engage in PIPE environments appear more able to talk about their feelings, address conflict and more appropriately seek help. Preston (2015) refers to the process of having a culture of enquiry within PIPEs, which helps staff to facilitate communication for residents, giving them the chance to explore what they are feeling when they “act out” to support them to get to the point where they can “talk out”. An emphasis on openness within communication links to literature on the therapeutic alliance (Guthrie et al., 2017) within therapeutic relationships (see attachment section).

**Inclusion**

Inclusion reflects the importance of everything that occurs, having the potential to be used to therapeutic effect. It requires the sum of the experience of all the members, all the time, to bear in understanding themselves in relation to the environment. Hearty et al. (2016) found that staff and prisoners perceived the DRW as a community, there was an emphasis on support from prisoners and the majority of prisoners felt that their peers were supportive and encouraging to a greater degree than they had experienced previously.

**Agency**

The culture of environments is one in which responsibility for all that happens (within specific limits) is shared; members are empowered to take whatever action is decided. Hartmann et al. (2009) report that when leaders create a strong entrepreneurial culture which promotes: initiative taking, group learning and innovative approaches to problem solving, this culture informs action in dealing with patient safety issues. Hasselrot and Fielding (2010) reinforced this, suggesting that the approach and attitudes of staff influences the culture of a forensic setting, in not allowing it to become destructive, and Senker (2015) who identified the importance of having choice to make decisions, and how this can help foster an encouraging environment.

Some of the identified problems associated with establishing and maintaining positive environments in forensic settings come from the conflicting aims that are associated with custodial environments. Taxman and Ainsworth (2009) highlight the conflicting goals (sentence vs treatment) or operational goals (security vs treatment) and the impact this can have on therapeutic work offered to offenders, and the negative effect this can have on support for rehabilitative efforts. For example, Ross (2008) points out how a therapist might encourage and foster a therapeutic and calm environment in the therapy room that can be undone out in the exercise yard in a single confrontation with a custodial officer. Hearty et al. (2016) also suggested a disparity in the role wherein prison officers felt caught between the care and discipline aspects of their roles.

**Enabling environments in the UK**

Johnson and Haigh (2011) describe the development of the EEs initiative in the UK, which commenced when the Royal College of Psychiatrists identified a need to capture work that was occurring in environments not within the scope of existing frameworks such as those underpinning the work within therapeutic communities (Paget et al., 2015). The project
developed to produce a set of comparable core principles and standards applicable in non-TC settings. The EE principles derived from the experiences of ordinary individuals on what it is that bind communities together, thus generating a series of considered principles for environments. Ten core standards[2] were developed (see Johnson and Haigh, 2011) that work together to foster an EE. EE in the UK, as defined by Royal College of Psychiatrists, College Centre for Quality Improvement (2013) are as follows:

- places where positive relationships promote wellbeing for all participants;
- places where people experience a sense of belonging;
- places where all people involved contribute to the growth and wellbeing of others;
- places where people can learn new ways of relating; and
- places that recognise and respect the contributions of all parties in helping relationships.

The EEs award in the UK arose from the idea that some agencies may wish to pursue and demonstrate service improvement by being objectively assessed leading to formal accreditation and an award of EE status. The award is based on a portfolio of evidence, assessment visit and discussions with service users, staff and stakeholders for external verification (Johnson and Haigh, 2011).

**Aims of the current review**

The objective of this review is to identify the impact of enabling and/or therapeutic environments in forensic settings on wellbeing, desistance, mental health and relationships for patients and staff living and working with these environments.

**Method**

**Search strategy and terms**

The search strategy aimed to find both published and unpublished studies. Various databases and journals (PsychINFO, PsychEXTRA, Web of Science, Criminal Justice Abstracts and SCOPUS) were explored for relevant publications relating to environments in forensic settings. Search terms and combinations are depicted within Table I.

<table>
<thead>
<tr>
<th>Table I Search terms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ENABLING</strong> OR <strong>THERAPEUTIC</strong></td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td><strong>ENVIRONMENT</strong> OR <strong>MILIEU</strong> OR <strong>CLIMATE</strong></td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td><strong>FORENSIC</strong> OR <strong>CORRECTION</strong> OR <strong>CRIM</strong> OR <strong>LEGAL</strong></td>
</tr>
<tr>
<td>[CORRECTIONS/CORRECTIONAL] [CRIMINOGENIC/CRIME/CRIMINAL/CRIMINAL JUSTICE]</td>
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<td>AND</td>
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<td><strong>OFFENDER</strong> OR <strong>PRISON</strong></td>
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<td>[PRISONS/PRISONERS]</td>
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*Note: *Indicates that the search term was entered as written to ensure the terms listed within square brackets were also found.
Inclusion and exclusion criteria

The inclusion and exclusion criteria were chosen to capture and review the most relevant empirical studies, focusing purely on factors relating to enabling and/or therapeutic environments within forensic settings. Inclusion criteria are as follows:

- studies exploring the experiences of residents within enabling/therapeutic environments;
- outcome studies for improved relationships, wellbeing, mental health or desistance linked to the therapeutic environment/climate;
- studies using validated tools measuring therapeutic environments/climates;
- international studies included;
- adult males over 18 years; and
- published after 2008.

Exclusion criteria are as follows:

- not English language;
- not peer reviewed;
- book chapters;
- not a forensic setting; and
- focus on therapeutic communities.

Figure 1 presents a detailed flow diagram illustrating the search and screen-out pathway.

The remaining 15 studies were appraised using the following protocol. Qualitative studies were appraised using the National Centre for Social Research, Quality in Qualitative Evaluation framework (Spencer et al., 2008). In total, 18 quality indicators are considered and rated as present or absent[3]. Quantitative studies were appraised using the Effective Public Health Practice Project, quality assessment tool (Effective Public Health Practice Project (EPHPP), 1998). From applying the above, six studies were excluded based on weak ratings (quantitative, \( n = 5 \)) or low number of quality indicators (qualitative, \( n = 1 \)). Nine studies remaining for inclusion in the systematic review.

Synthesis of data

To facilitate comparison and synthesis of data across studies, information was gathered using a data extraction tool (Jones, 2007), before being tabulated. The nine papers were scrutinised to present general similarities and comparisons in order to present an overview. Following this, key themes were identified.

Results

Description of studies

Methods breakdown. Four of the studies were quantitative and four were qualitative. One design was mixed methods. The qualitative methods utilised were as follows:

- thematic analysis;
- interpretative phenomenological analysis (IPA);
- Foucauldian discourse analysis (FDA); and
- observational/field notes.

The mixed method study utilised a convergent mixed methods approach with thematic analysis for the qualitative component.
The quantitative study designs were as follows:

- 2 x 2 between groups design (n = 1);
- case control study (n = 2); and
- cohort study (n = 1, one group pre + post (before and after)).

**Contextual information**

Three of the qualitative studies focussed on PIPEs in UK custodial environments (Bennett, 2014; Bond and Gemmell, 2014; Preston, 2015). The remaining qualitative study took place in a UK prison that focusses on rehabilitation of sexual offenders (Collins and Nee, 2010). The quantitative studies took place in a variety of therapeutic and rehabilitative focussed establishments. These included establishments focussed on the needs of violent offenders (Casey et al., 2016; Day et al., 2012) sexual and violent offenders (Woessner and Schwedler, 2014) and offenders with substance abuse treatment needs (Kubiak, 2009). The mixed method study took place in an establishment focussed on the treatment of sexual offenders (Blagden et al., 2016).

**Geographical location and study focus**

All qualitative studies took place within the UK. The three studies that occurred within PIPEs focussed on the experiences of staff (Bond and Gemmell, 2014) and the hopes/expectations/
experiences of residents in these environments (Bennett, 2014; Preston, 2015). The remaining qualitative study focussed on the factors influencing change in sex offender treatment from the perspective of facilitators (Collins and Nee, 2010).

The quantitative studies were more internationally focussed, with studies from Australia (Casey et al., 2016; Day et al., 2012), Germany (Woessner and Schwedler, 2014) and the USA (Kubiak, 2009). The focus was on factors that could influence the quality of environments (e.g. incarceration length, protective custody status, treatment units vs non-treatment units) and the influence of environments on other factors (e.g. risk of reoffending). The mixed method study (Blagden et al., 2016) took place in a European prison and focussed on the experiences of prisoners and staff at a therapeutically orientated sexual offenders’ prison to understand whether the prison environment was conducive to rehabilitation.

Participant characteristics

Six studies focussed exclusively on offender participants (qualitative $n = 3$; quantitative $n = 3$). One study focussed exclusively on staff participants (qualitative $n = 1$). Two studies focussed on offender and staff participants (mixed method $n = 1$; quantitative $n = 1$). Offender participants within the studies were from a range of security categories of prison (high to medium) and secure units. All offender participants were male, with the exception of a larger scale quantitative study that had a female participant group (Kubiak, 2009). All offender participants had committed offences of a serious sexual or violent nature. Some offenders had completed treatment and some had not. Other demographic data consistently collected across the studies included details of sentence length, and age. Some variability was observed with data pertaining to treatment needs and personality factors.

Staff participants were mixed male and female. The roles captured within the staff participant categories (e.g. Blagden et al., 2016) ranged from discipline staff, psychological staff, senior managers and other grades (e.g. librarian). The majority of studies reported the length of time staff had been in post. All studies reported the age range of staff.

Themes from the review

From reviewing the studies, three superordinate themes with subthemes within them were identified, described in Table II.

Factors required for successful environments

This superordinate theme consists of themes of purpose and shared identity, safety, relationships, and autonomy.

Purpose and shared identity. Blagden et al. (2016) highlight the importance of purpose and shared identity for those residing in EEs, but also for the establishment itself, suggesting that purpose and shared identity is an institutional consideration as well as an individual one.

<table>
<thead>
<tr>
<th>Factors required for successful environments</th>
<th>Factors that impact successful environments</th>
<th>Factors affected by successful environments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose and shared identity (Blagden et al., 2016)</td>
<td>Intrinsic or extrinsic motivation (Bennett, 2014)</td>
<td>Skills consolidation (Preston 2015; Bennett, 2014)</td>
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<td>Safety (Blagden et al., 2016)</td>
<td>Staff roles (Bond and Gemmell, 2014; Collins and Nee, 2010)</td>
<td>Belonging (Bennett, 2014)</td>
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<tr>
<td>Relationships (Blagden et al., 2016; Bond and Gemmell, 2014; Preston, 2015; Day et al., 2012; Kubiak, 2009)</td>
<td>Perception from within (Casey et al., 2016)</td>
<td>Identity (Blagden et al., 2016)</td>
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<td>Autonomy (Woessner and Schwedler, 2014)</td>
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<td>Treatment readiness and readiness to change (Blagden et al., 2016; Day et al., 2012)</td>
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<td></td>
<td>Change and growth (Collins and Nee, 2010; Blagden et al., 2016; Bond and Gemmell, 2014; Woessner and Schwedler, 2014; Kubiak, 2009)</td>
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The interaction between the offender participants and the environment is important but not exclusively related to positive outcomes. Participants have to want to change or engage, meaning individual motivation is significant and the environment can help to encourage this desire to change. They discuss how the establishment where they conducted their study focused on treatment of sexual offenders, which supported the development of the culture of rehabilitation as integrated into all aspects of the prison culture rather than viewing the treatment in isolation. It stands to reason, therefore, that for better outcomes establishments need to have a clearly defined purpose and set of goals that are integrated and pervasive throughout the establishment and culture, to help to support those residing within it to develop their own purpose and identity which would ideally replicate that of the establishment, e.g. rehabilitation and desistance.

Safety. Safety was found to be a core component in establishing a successful environment (Blagden et al., 2016) and furthermore, the attitudes of staff towards residents were linked to the perception of the environment as “safe” by those residing within the environment, thus suggesting that the more positive the staff attitude the more safe residents felt.

Relationships. Relationships between staff and residents within environments are identified in a number of the studies as a key requisite for environments to be perceived as positive and successful against their primary aims. Relationships consist of the attachments and connections that staff and residents make (Bond and Gemmell, 2014) and should be characterised by supportive, constructive, open and genuine interactions (Blagden et al., 2016; Day et al., 2012). These relationships link to positive outcomes (Bond and Gemmell, 2014) which could include the ability of residents to set goals, recognise and express emotions (Preston, 2015).

Kubiak (2009) identified that a key difference in the ratings of environments (treatment vs non-treatment) were residents’ perceptions of the staff who worked within the units. Participants in EEs consistently rated discipline staff more positively than their counterparts in comparable units did, on characteristics associated with a therapeutic milieu (e.g. accepting and understanding).

Autonomy. Woessner and Schwedler (2014) identified that perceptions of restrictions in autonomy are important to consider in positive environments. Lack of, or restriction of, autonomy relates to the extent to which offenders feel patronized and restricted during imprisonment, which is arguably common in forensic environments. However, the authors do not comment on possible reasons for autonomy being important when creating positive environments. Other literature in this area suggests that allowing choice and input into decisions, i.e. facilitating autonomy, helps to foster a positive, safe environment, although staff and establishments can be fearful of this approach particularly in custodial settings where there is a strong emphasis on hierarchy, rules, policies and control. Arguably, these aspects can inhibit a positive climate for safety due to fear of negative outcomes and blame for reporting safety-related problems (Hartmann et al., 2009; Senker, 2015).

Factors that impact on successful environments

The themes within this superordinate theme are motivation, staff roles and perception from within.

Motivation. Bennett (2014) highlights the importance of considering motivation of clients when reviewing referrals to the PIPE service. The aim of progression PIPEs is to consolidate and generalise learning, to contribute to the overall OPD pathway aim to reduce risk. However, some offender participants in the study focussed more on the risk reduction aims of the service. Bennett hypothesises that outcome could be different for an offender who was motivated intrinsically by the desire to generalise their skills and achieve prosocial goals, compared to an individual who is extrinsically motivated to reduce their risk. Although not mutually exclusive, it is not possible to identify whether the participants in this study were intrinsically motivated, extrinsically motivated or a combination and therefore, whether there is an impact on the data. However, research suggests that individuals who participate in qualitative research are likely to do so because of subjective interest, enjoyment, curiosity, introspective interest, social comparison and therapeutic/material/economic interest. These characteristics could be more congruent with individuals motivated to engage generally for internal reasons (self-development) rather than
external reasons (perceptions of risk), which could mean these data are more reflective of outcomes specific for this group of individuals. In our opinion, if participants are intrinsically motivated they may be more likely to view their environments positively and derive the benefits they can from residing within them.

**Staff roles.** Staff roles were highlighted by Bond and Gemmell (2014) who explored the experiences of prison officers working in a PIPE designed for life sentence prisoners. The theme “role conflict” identified by Bond and Gemmell relates to the “staff roles” theme identified in this review and it explains the conflict between rehabilitation and punishment. Throughout the analysis, there is a sense of what it means to be a prison officer and how the type of work they are completing affects this; leading officers to development of a type of hybrid role working on a PIPE. The rejection of aspects of their past role can lead to peers rejecting the staff that have adopted this new way of working. In our opinion, this paper evidences a common process that appears to occur for PIPE staff. Specifically, the way they are learning about themselves, developing skills to understand others, viewing themselves, their identity and the work they are doing differently and adapting their behaviour according to the needs of the residents and the PIPE. This could equally influence the environment in a negative way if the staff do not adopt the appropriate balance.

Collins and Nee (2010) identified a similar theme in their research labelled “operational conflict”. Traditional prison culture and/or values view the security role as paramount, over and above any rehabilitative effort and is dominated by risk-avoidance emanating from political pressure to avoid making mistakes. Participants believe that this cultural dynamic featured negatively in the interactions between non-treatment staff and group participants. For example, non-treatment staff undermining the rehabilitative effort made by individual offenders and potentially undermining any rehabilitative culture developed during treatment. Participants felt the behaviour by non-treatment staff affected the relationships with authority generally, and may affect the successfulness (or lack of) of the intervention in question.

**Perception from within.** This theme reflects factors that can influence the participants’ perception of the environment and may influence the success of environments. Casey et al. (2016) found that the longer individuals resided in a specific environment, the more positive their assessment of the environment was. In the same study, individuals who were located in protective custody rated the environment more positively than individuals not in protective custody. The features felt to distinguish the environments (protective vs non-protective) from one another were the more positive, supportive relationships between residents and staff, and with each other. This theme links to the relationships theme identified within the superordinate theme: factors required for successful environments; perhaps in order to develop the relationships required for successful environments, there is a need to consider the length of time required in the facilitation of these relationships.

**Factors affected by successful environments**

This superordinate theme consists of the themes of skills consolidation, belonging, identity, treatment readiness/readiness to change and change and growth.

**Skills consolidation.** Preston’s (2015) paper applies narrative identity theory (McAdams, 1994) to the experiences of men in a high-security PIPE using observational and anecdotal methods to try to make sense of the experiences and processes occurring. Preston highlights that residents feel the environment is safe enough to try new skills and goes on to describe the process as a “pendulum swing” whereby residents try out different skills and behaviours, at times over or under compensating, before achieving the appropriate balance of skill application. She also highlights the process of feedback as being central to the process of skill consolidation. Preston comments that the safe environment allows the participants to reconnect with their emotions, and identify and manage these in different, more contained ways. It is reasonable to assume that residents would not feel able to try their new skills in an environment that is not safe. This supports the previously identified sub-theme “safety” as an important factor in successful environments, and a possible causal link between the components of safety and skills consolidation.
Bennett (2014) explored the experiences of services users within a high-security PIPE. The study is small (n = 5) and is limited to high security. As previously highlighted, the shared understanding of one function of progression PIPEs is consolidation and generalisation. The theme “progression” identified by Bennett describes the interpretation of a process for consolidation and generalisation that could be occurring within PIPEs. The process illustrates the importance of residents identifying the skills they have developed and need to consolidate, actively consolidating their skills, recognising and being recognised by staff for skills generalisation, and ultimately progressing through their sentence. It is not clear from the data whether this process occurred with the residents sampled or if this was hoped/expected to occur but fits broadly with the hypothesis made by Preston (2015).

Belonging. Bennett’s (2014) second theme “being part of a community” could link to the EE process and is a conceptual argument for the process that residents may go through to achieve one of the core standards of “belonging”. It is hypothesised by Bennett that residents need to focus on “intrapersonal self-development which would enable participants to pro-socially interact with others on the PIPE” (p. 223) thus contributing to a sense of belonging. This contributes to positive environments by the value that residents derive from belonging to a community and the value the community gains by its residents’ increases in confidence, autonomy and participation. However, it is not clear from the analysis that the process reported occurs in the order described for the residents sampled.

Identity. Blagden et al. (2016) highlights the role the environment plays in the identity of those within it, i.e. that residents can be themselves rather than portray an identity that could help them to “survive”. This is reflected in the safety participants felt in their environment. Similar thinking around the impact that environments have on identity is reported by Preston (2015) who suggests that residents feel safe to try new ways of being, which can lead to the identification and encouragement of narrative shifts between institutional and empowered narratives. The institutional narrative is characterised by themes of negativity, pessimism, disillusionment and blaming. The focus is often on the past, with little hope for the future. A preoccupation with a “system approach” dominates; individuals have no agency over their own decision making and that they exist as part of as system, rather than in their own right as an individual. The empowered narrative includes positivity, hope, motivational statements and personal goals. It focuses on an individualised approach with responsibility taking being a thread that runs throughout. It includes recognition of choices and opportunities and is future focussed. Ellis and Bowen (2017) suggest that positive social environments can contribute to internal shifts, perhaps reflecting the shifts identified above by Preston (2015) and this has important implications for desistance research.

Treatment readiness/readiness to change. Blagden et al. (2016) found that prison climate predicted readiness for treatment and correlates with beliefs that offenders can change. The authors highlight that staff belief in the possibility of change in offenders contributes to the positive environment rating. Staff perception of the prisoners’ internal readiness to change also contributes to the positive environment; however, prisoners’ belief in the possibility of change does not contribute to the positive environment rating. It is unclear why there is this distinction but the authors suggest environments alone are not sufficient for change; individuals have to be motivated to change. This is consistent with the previously identified theme of motivation (Bennett, 2014).

Based on the data analysed, Day et al. (2012) reported that staff and prisoners in the specialist treatment prison rated the social climate of the prison as more conducive to rehabilitation when compared to the mainstream prison comparison group, although the differences in the ratings of the environment were less pronounced for prisoners. The authors note that for those prisons that have adopted a specific treatment focus, it seems reasonable to suggest that social climates characterised by high level of social cohesion, mutual support and safety are those that are likely to be successful in rehabilitating offenders which concurs with research previously discussed above (Blagden et al., 2016).

Change and growth. Blagden et al. (2016) found the climate was rated positively and, in particular, participants had very high ratings of “experienced safety”, which appeared important for allowing individuals the space to deal with their problems, engage in treatment programmes
and also grow and develop in personally meaningful ways, e.g. focussing on their offending behaviour, thinking about the self and future self.

Bond and Gemmell (2014) identified a theme from staff interviews entitled “growth”. Arguably similar to the residents’ experiences, this theme reflects the personal journey that staff take as they become more psychologically aware about themselves and the residents they are working with. It includes a deeper understanding of the residents they are working with, personal learning, and reflective skills.

Woessner and Schwedler (2014) found that treatment gains related to a more favourable rating of prison climate. They found medium-sized prosocial changes to the dynamic risk factors of pro-criminal attitudes and anxiety/neuroticism in all offenders, although antisocial personality patterns only decreased among violent offenders. With the exception of empathy, psychometric change correlated with ratings of prison climate, with prosocial changes relating to more positive climate ratings.

Kubiak (2009) found the long-term outcome evaluation of the residential substance abuse treatment programmes studied have yielded findings that indicate less recidivism and relapse than matched comparison groups but it is unclear whether this can be attributed to the environment, programme or a combination of both components.

Discussion and conclusion

This review has sought to identify the outcomes for residents and staff living and working in forensic environments. A trio of themes illustrates some factors required for successful environments, factors that can affect the success of these environments, and provisional outcomes attributed to the environments.

The focus of developing environments that empower and heal those that reside within them is not new, and the application within custodial settings is no different, with therapeutic environments being created as early as 1942 at the Northfield secure Military Hospital in Birmingham (Bridger, 1990), and HMP Grendon in 1962. The more recent developments in awareness within HMPPS of the importance of therapeutic environments more widely within custodial settings, illustrate a shift in thinking that therapeutic environments do not have to be isolated from the rest of the establishment or system. They can and should be integrated into establishment/system ethos, to the enhancement of desired outcomes, e.g. reduced levels of violence and self-harm. This is evident within theme one, emphasising the importance of such environments not being isolated from the whole, that the culture of an establishment requires a shared identity and focus. Also emphasised within this theme is the importance of the staff interactions. This highlights an ongoing conflict in the perception of the role of the prison officer between more traditional perspectives of a security and punishment focus to a more rehabilitative, psychologically informed focus (Guthrie et al., 2017), a similar process to that which is occurring within the system as a whole. This is supported by subtheme “staff roles” within Theme 2. Therefore, the expectation that staff should work in this more rehabilitative style has to occur in conjunction with similar overall cultural shifts, in order that staff feel supported and confident to work in this way, to contribute to successful environments and subsequent outcomes.

Theme 2 also identifies other factors that may influence how successful environments will be, which may have relevance to those currently working within such environments. This theme is perhaps the least understood within the literature given the challenges associated with distinguishing what is underlying the factors identified. For example, Casey et al. (2016) indicate that length of time within an environment is related to perceptions of that environment, but a number of factors might be effected by time, for example, perceptions of safety, depth of relating to others, confidence, etc. An individual offender’s motivation is a factor that might influence the success of therapeutic environments, but can be an outcome of engagement in such environments (theme 3). Conceptually this is extremely challenging, as ultimately, incarcerated is not something that individuals are typically motivated to be. Conversely, they may be motivated to not be incarcerated, and view engagement in these environments as a means to achieve this goal.
Therefore, considering motivation more generally and how to promote this in a population that is perhaps less inclined is an ongoing area for research.

Less research has focussed on the possible outcomes of environmental interventions, due partly to the difficulty in attributing change to environmental conditions or other interventions offered. This review has highlighted some provisional findings that could directly relate to the environment, which investigation through further research could develop. One such area might be in the area of insight. Within the majority of the subthemes identified, there is an element of personal insight noted, including, individual identification of need to focus on a particular area (Bennett, 2014; Preston, 2015), recognition of personal identity (Blagden et al., 2016) and staff development and growth (Bond and Gemmell, 2014).

**Strengths and limitations of the current review**

The use of the systematic review method is a more robust way to review the specific question outlined, and the use of appraisal methods through classifying the quality and characteristics of studies against standardised criteria allows a more critical review of the studies and therefore prioritises empirical evidence over preconceived knowledge. However, the evaluation of qualitative studies is also more open to interpretation than quantitative studies. Within this review utilised the method developed by Spencer et al. (2008). After assessing the presence of key indicators, the method does not provide an overall categorical way of deciding how methodologically robust a study is we opted, therefore, to consider the higher number of present indicators being indicative of a higher level of methodological quality for the purposes of categorising the studies within this review. Other methods could be consider the indicators with a higher degree of priority (rather than just numbers) in relation to the research question, in order to assess the methodological strengths and weaknesses of the qualitative studies within this review. This may have influenced the outcome of the review in the inclusion/exclusion of studies that may or may not have had utility in answering the research question.

The inclusion and exclusion criteria may also influence the quality of this review. Restricting articles for inclusion to those written in English is a limitation because of potentially missing additional studies. There is some lack of generalisability of the review to female and young people (although some of the underlying principles may apply); and this is an area for further exploration. The year of publication also may have resulted in the exclusion of relevant studies; however, the importance of having up-to-date knowledge and evidence negates this somewhat.

**Strengths and weaknesses of the studies**

The challenge of comparing studies within this review is the lack of consistent method to assess the presence or absence of key environmental factors. One area where comparisons are robust is through the application of a consistent set of standards, such as those described within the EE framework, present within some studies in this review (Bennett, 2014; Bond and Gemmell, 2014; Preston, 2015). This adds a degree of consistency to comparisons between these studies, but not to international studies included in the review. Comparisons between therapeutic environments with different quality standards may therefore influence the outcomes of this review in emphasising the importance of some factors or not noticing factors that may be important. Completing distinct reviews wherein a criterion regarding the application of the accredited EE’s award or other standard measure of environments (e.g. community of communities) may yield relevant findings to further understanding of the factors associated with environments in forensic settings.

The way in which social climates are assessed within the studies in this review presents some points for discussion. Of the quantitative studies, three (Day et al., 2012; Blagden et al., 2016; Casey et al., 2016) utilised the EssenCES, with one study (Kubiak, 2009) using the correctional institution environment scale (Moos, 1987) and one utilising an adapted measure (Woessner and Schwedler, 2014) from the work of Ortman (1987). The concepts assessed by these measures are similar but differ in some areas, and this can make meaningful comparisons of outcomes in a review of this nature challenging.
**Implications for practice and future research**

Understanding what might be an optimal length of time for individuals within supportive forensic environments is challenging and, at present, services do have minimum and maximum time limits, although how much this relates to outcomes as opposed to service requirements for spaces is unclear. The findings from this review suggest that a longer period may be beneficial, and further investigation into this issue might be of use.

The nature and type of motivation individuals have for engaging within supportive forensic environments is an area for further exploration. For current services, a more structured assessment of motivation might be a useful addition to assessment procedures, in order to understand and address individual’s needs. Motivation was a factor thought to influence successful environments, but also as an outcome of successful environments. It may be useful therefore for further research to explore types of motivation and the impact on successful environments, and subsequent outcomes for individuals.

In conclusion, this review has sought to explore forensic environments, with focus on the outcomes attributable to the environment. This has been achieved, with additional findings supporting the requirements for successful environments and areas that may influence environments. Going forward, it is anticipated that supportive forensic environments is an area that will continue to expand and result in further research to continue to make improvements to environments and those within them.

**Notes**

1. Drug recovery wings (DRW) adopt a similar focus on the environmental aspects to support recovery of offenders who have substance misuse problems in UK prisons.

2. Belonging, boundaries, communication, development, involvement, safety, structure, empowerment, leadership and openness.

3. No guidance is given to overall strength of the studies or categorising studies according to numbers of indicators, it was concluded that studies with the number of indicators as six or less would be considered weak and therefore excluded.

4. The specific findings for the female participant group were excluded from the themes from this review due to being an exclusion criterion.

5. Protective custody prisoners are separated from the mainstream prison population by either segregation or protection, within a rehabilitation-focused treatment facility. Non-protective custody prisoners were housed in small living units that focused on treatment for violence or substance misuse.

**References**


Senker, S. (2015), "Applying models of forensic psychology to therapeutic environment", presentation from the Division of Forensic Psychology Annual conference, Manchester 1 July.


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Chronicles of one woman’s journey towards well-being: response-ability

Jo Mullen

Abstract

Purpose – The purpose of this paper is to share the experiences and reflections of one woman’s journey towards well-being.

Design/methodology/approach – A narrative approach has been taken to structure reflections based on a lived experience.

Findings – Reflections are offered based on a personal journey towards well-being.

Originality/value – This paper adds to the accounts of the lived experience of the journey towards well-being, and as such, contributes to the understanding of the process of rebuilding a life.

Keywords Responsibility, Autonomy, Awareness, Trauma, Choice, Anxiety

Paper type Viewpoint

Self-awareness and self-honesty are essential steps along the journey of self-healing (Holden, 1992, p. 43).

For many years, I have endeavoured to follow the maxim, “Know thyself,” as directed by the Oracle at Delphi, the Hindu Upanishads and countless others. However, it could well be the case that this constant pressure to pursue self-knowledge has led to the plethora of troubled thoughts and my perpetual state of unease. I do, at the same time, however, hold onto the hope that by expanding my awareness, by reaching for deeper levels of truth, I will, in the end, arrive at a place of wisdom, and beyond that, achieve a sense of peace. Though somewhat perturbed by this dialectical conundrum, I am heartened by my basic understanding of quantum physics, that opposing states can exist simultaneously until an action is taken. In other words, all things are possible until a choice is made. But I cannot make the “best” choice without first acknowledging my current position.

You may recall the realisation I had come to previously, namely that a phenomenon known as “toxic stress”, had resided within my mind and my body for most of my life. Well, afterwards, I resolved to tackle the problem of my long-standing anxiety. I have been aware for some time now that I am most vulnerable to attack when required to leave the sanctuary of my house to satisfy some external expectation or demand. So, a couple of months ago, I made a promise to myself: I would only venture outside my front door if I chose to. This of course, presented me with yet another challenge – could I occupy myself sufficiently, and with purpose, despite avoiding most social contact? Fortunately, I can report a respectable degree of success on both fronts.

First, my overall levels of anxiety and obsessive planning have greatly reduced as a result of my self-imposed stay-at-home-ness, allowing me the freedom to opt for long afternoons with friends and dogs in the country when the mood tempts me – an altogether normal response (when I compare myself with others) to the delicious weather we have all been enjoying.

Second, I have become determined in my efforts to engage in activities that do not involve social interaction. For example, I have renewed my interest in reading, opening up opportunities for virtual travel as I explore other worlds – all without having to endure the pain of negotiating a bus, a train or a public space in order to reach my destination. I even attended a conference from
my office, tuning into the Healing Trauma Summit, a live event transmitted over the internet by Sounds True. I felt especially pleased with this as the summit featured well-known speakers who would be presenting their work in person a couple of weeks later at the Trauma Conference in Belfast, where the jostling crowds would no doubt have frightened me.

Through this experience I learnt how different therapies, developed by leaders in the field such as Peter Levine and Pat Ogden, share a common belief that, “everything the body does has meaning” (Ogden, 2018). Gabor Maté, another Expert interviewed for the online event, goes further to state that:

> For the adult, therefore, biological stress regulation depends on a delicate balance between social and relationship security on the one hand, and genuine autonomy on the other. Whatever upsets that balance, whether or not the individual is consciously aware of it, it is a source of stress (Mate, 2003, p. 198).

I can relate to this all too well; when my personal boundaries have been compromised in the past, I have given up my own needs far too readily. On many occasions, it is as if I have driven a pestle deep inside myself so that any grains of natural resistance that might have risen up to protest were immediately ground down before they had a chance to agitate the smooth surface of the sturdy mortar that contains me. But, on just one occasion, on one day recently, I broke out of my mould. Someone in my life, a person with whom I usually enjoy a close relationship, barred the way to an experience I had planned and was looking forward to.

The emotional eruption in me was immediate…

Explosive!
Ferocious!
Righteous!

I raged impressively to myself and to select others about the injustice. I did not restrain it. Instead I unleashed the murderous energy, and watched it spread across far continents and distant planets. Out and out it went until eventually it arrived at a point of natural dissipation, and then finally, it came to rest. Then, as I surveyed the crime scene around me, I was shocked to find it devoid of regret, of guilt – and even my familiar inner judge was nowhere to be found. The very next day, the pain in my hands that had plagued me for months, completely disappeared. Truly a miracle! “And you know what”? I observed, “No-one died”.

This situation takes me back 20 years to the start of a residential workshop that was delivered by the members of the well-known Findhorn Foundation here in the North East of Scotland. We were invited to make a random selection from a pack of Angel cards. I looked at the card I had chosen. On it was written “responsibility”. I was visibly disappointed, not wanting to carry the burden of such a serious quality with me for the entire week. Then, another person in the group intercepted my thoughts with:

> Oh no – it’s not bad! It simply means you’ll be equipped with the “ability to respond”. Now, when I think back, I can appreciate the wisdom of that definition, of using my ability to respond; to make choices; and to protect my right to be autonomous.

I will leave you with a poem that I wrote for a woman in my community who, along with others, I had the privilege to support towards the end of her life. She said that she had many regrets. This made me sad, so I offered her the gift of a different perspective:

**It matters**

It doesn’t matter if you chose
The wildest sea or the stillest pond
It doesn’t matter if you chose
The raging wind or a gentle breeze
It doesn’t matter if you chose
The tallest mountain or the smallest stone
It doesn’t matter if you chose
A furious passion or the subtlest love
And it doesn’t matter if you chose
A life on earth or a life elsewhere
But it matters that you chose.

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