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Feasibility and Impact of Recovery-Oriented Practices in an Italian Mental Health Service: A Pilot Study

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Abstract

Background

In the last decade, Italy has made progressed in adopting the personal recovery-oriented approach. However, full adherence to international recommendations for implementation remains incomplete.

Aims

This study aimed to explore the feasibility, acceptability, and impact of integrating recovery-oriented practices in an Italian Mental Health Service (MHS).

Methods

This pilot study used a longitudinal design with two focus groups. At baseline and follow-up data collected was users' socio-demographic and clinical characteristics, symptoms, functioning, needs for care, functional autonomy. The Mental Health Recovery Star (MHRS) was used to facilitate and monitor recovery. Professionals and users provided feedback using qualitative interviews. Descriptive analyses were conducted.

Results

Nineteen professionals completed the MHRS with 25 users. From baseline to follow-up users showed an increase in romantic relationship ($p<0.001$), employment ($p<0.001$) and addiction ($p<0.001$), and improvements in the MHRS ($p=0.003$), functioning ($p=0.015$), psychopathology ($p=0.001$), functional autonomy ($p=0.003$), along with a reduction of unmet needs ($p=0.026$). Focus groups witnessed active and consistent participation. Both professionals and users positively assessed the study, expressing a desire for more education on recovery, and, generally, saw improved satisfaction and recovery-oriented approaches from baseline to follow-up. Professionals reported higher motivation for work, while users reported comfort sharing views and greater involvement in care, despite some challenges with adherence and collaboration.

Conclusions

The findings indicate the potential for recovery-oriented practices in the MHS, though further efforts are needed for full integration.

1. INTRODUCTION

Across Europe, since 2005, various international recommendations, including the Declaration on Mental Health for Europe (1), the European Commission's Green Paper (2), and the United Nations Convention on the Rights of Persons with Disabilities (3), have emphasized the importance of upholding the human rights and fundamental freedoms of individuals with disabilities (4).The NICE guidelines (5) have

strongly advocated for the provision of care for individuals with psychosocial disabilities predominantly in community settings, involving all stakeholders and adopting a flexible and recovery-oriented approach.

Anthony defines recovery as a deeply personal and transformative process that encompasses changes in attitudes, values, feelings, goals, skills, and roles. Despite limitations caused by their psychiatric disorder, individuals can lead a satisfying, hopeful, and meaningful life (6), encompassing various adulthood roles at home, work, school, and other social areas (7–9).

The implementation of the recovery model in Mental Health Services (MHSs), particularly through evidence-based recovery-oriented practices (10–12), has resulted in improved user self-management, self-efficacy, autonomy (8, 13), as well as enhanced health and social outcomes (14–16). These practices are considered essential for adapting MHS to the needs of the current century and correlate positively with treatment outcomes improvement and reduced health costs (10, 17–19).

Current MHS objectives should aim to provide continuous care for individuals with mental disorders, focusing on personal recovery and rehabilitation (20), personalized and shared treatments (17, 21–23) that integrate the recovery paradigm with evidence-based medicine (24, 25) and valorize the user's and their family's experiences in developing personalized, user-centered projects (5, 17, 23).

In Italy, there is potential to foster the adoption of recovery-oriented practices due to the existing tradition of community care (26). Over the past decade, essential elements of the personal recovery approach have emerged (27–30), including the collection and dissemination of recovery stories to inspire and provide hope to users, families, and professionals (27, 31–33). Co-production and peer expertise initiatives have been implemented in various Italian settings (34–36), while recovery-oriented interventions have been integrated (37) into critical life dimensions such as work (38–40). Moreover, specific training programs on personal recovery have been developed for mental health professionals (26), and tools for facilitating and assessing personal recovery have been created or translated from other languages (41–45).

However, the implementation of recovery-oriented practices in Italian MHSs has not fully met international recommendations. The adoption of the recovery paradigm remains a challenge for many professionals who are accustomed to paternalistic approaches (27, 46). Treatment and intervention specificity is often lacking, and the establishment of care pathways that prioritize user real needs and satisfaction can be difficult (26, 32, 47).

Jim van Os and colleagues have suggestest the need for pilot projects to investigate the feasibility and integration of recovery-oriented practices in clinical work (21, 48).

The objective of this paper is to present a small-scale study that explores the feasibility, acceptability, and impact of implementing and integrating recovery-oriented practices within an Italian MHS. The study was conducted in the South-Verona MHS in Italy, which is characterized by a long tradition of evidence-based medicine and bio-psycho-social model approach (49).

2. MATERIALS AND METHODS

2.1 Study design

The current pilot study employed the Mental Health Recovery Star (MHRS) in a longitudinal study and focus groups to guide everyday practices and activities toward personal recovery-oriented approach. It was run from May 2017 to October 2018 in the MHS located in the South of Verona.

2.2 Longitudinal study

This small prospective cohort study took place from October 2017 to October 2018, with data collected at recruitment and a six-month follow-up, aligned with evaluation practices in Italian rehabilitation settings. The study was designed as exploratory due to the limited number of participants available for recruitment.

2.2.1 Participants

Mental health professionals who met the following criteria were eligible to participate in the study: 1) working at the South Verona MHS, 2) trained in the use of the MHRS, 3) willing to participate, and 4) capable of recruiting at least one service user for whom they were the key professional or case manager (involving tasks such as drawing up care plans, co-orientating care, and acting as the main contact for family members and other carers).

A three-day training course in the use of the MHRS was conducted between May 2017 and October 2017, with the participation of forty-five professionals. Out of the 45 participants, 19 were recruited for the study. The reasons for non-recruitment were as follows: 15 did not work in the South Verona MHS, 8 declined to participate, and 3 were unable to recruit at least one service user into the study (Figure 1). The majority of the professional participants were female (78.9%), and over a third (36.8%) were psychiatry residents. Most participants (73.6%) worked in community-based multidisciplinary teams, and the mean length of time they had worked there was 137 (SD 122.2) months.

During the study, mental health professionals received monthly supervision from certified MHRS trainers and experienced staff, ensuring consistent use of MHRS and promoting recovery-oriented practices. There were twelve monitoring meetings with key professionals, each attended by around 10 participants (range 2 – 23). When necessary, a research team member also participated in professional-user meetings to facilitate MHRS utilization.

Service users were recruited to the study based on the following eligibility criteria: 1) having a key professional or case manager trained in the use of the MHRS, 2) residing in the community within the catchment area of the South Verona MHS, 3) aged between 18 and 65 years, and 4) willing to complete a range of assessments at two time-points. Exclusion criteria were: 1) diagnosis of moderate or severe intellectual disability (50), and 2) being an inpatient in the psychiatric ward or at risk of admission due to the severity of symptoms during the study recruitment period. Eligible service users were identified by a

key professional or case manager, who explained the study's purpose and obtained written informed consent. Twenty-five service users were recruited.

2.2.2 Assessments

Socio-demographic, service use, and other clinical data of the service users were obtained from the Verona Department of Mental Health (DMH) database and the South-Verona Psychiatric Case Register (51). After a specific education and with the supervision of the research team, key professionals completed standardized assessments about service users at baseline and follow-up, including:

- The Personal and Social Functioning Scale (FPS) (42,43) assessed personal and social functioning. This scale examines four main areas: socially useful activities (including work and study), personal and social relationships (including family relationships), self-care and hygiene, and disturbing and aggressive behavior. The total score ranges from 1 to 100, with higher scores indicating better functioning.

- The Health of the Nation Outcome Scale (HoNOS) (52,53) investigated psychopathology and social functioning. The scale consists of 12 items covering four areas: behaviors that impact negatively on the person and/or others, problems with managing day-to-day activities, symptoms of mental disorder that distress or limit the person, and social, housing, and/or occupational problems that limit autonomy. Scores are given on a 5-point Likert scale (0 = no problem; 4 = very severe problem). Total score higher values reflect greater severity of psychopathology or lower functioning.

- The Monitoring of the Path of Rehabilitation (MPR) staff version (54) assessed the functional autonomy, evaluating the person's ability to independently perform various activities of daily living, such as self-care, housework, shopping, cooking, using public transport, accessing community activities (social and leisure), engaging in occupational activities, and managing physical and mental health. The total mean score ranges from 0 to 12, with higher scores indicating greater functional autonomy.

Both service users and key professionals completed the following tools.

- The Camberwell Assessment of Need (CAN) staff and patient version (55,56) to evaluate the needs for care, assessed using. The assessment comprises 22 items grouped into four domains: health, basic needs, service needs, and functioning. Each item is scored as 0 = no problem, 1 = no/moderate problem (met need), 2 = current severe problem (unmet need). The number of needs (scores of 1 or 2) and unmet needs (scores of 2) are aggregated over the 22 items, and the ratio of met to unmet needs is calculated.

- The MHRS (57,58) to facilitate and monitor the recovery process and recovery goals in a "expert to expert partnership" and exercising the shared-decision making process (21,59). The MHRS utilizes a 10-point star-shaped visual schema where each point corresponds to a life dimension: Managing mental health, Self-care, Addictive behavior, Living skills, Work, Responsibilities, Identity and self-esteem, Trust and hope, Social networks, Relationships. Service users, in collaboration with their key professional, rate their progress on each domain using a ten-point 'Scale of Change' (60) that describes five steps in the recovery process, divided into two phases:

1. Stuck (phases 1-2): feeling unable to cope with the problem or not accepting help for it.

2. Accepting help (phases 3-4): the desire to get away from the problem and the hope that someone/something can intervene to assist.

3. Believing (phases 5-6): starting to believe in the possibility of change, initiating actions to achieve personal goals, and accepting help from others.

4. Learning (phases 7-8): actively trying new approaches and learning through trial and error with support.

5. Self-reliance (phases 9-10): being able to achieve and manage desired goals without support.

After completing the ratings, the key professional and service user discuss and agree on specific recovery goals and develop a care plan to support their achievement. A maximum of three goals are worked on at a time.

- An impact assessment (61) to evaluate the impact of the recovery implementation in the MHS at baseline and follow-up. Participants were provided with both positive and negative statements to rate on a Likert scale from 1 (strongly disagree) to 5 (strongly agree). Staff members were provided with 11 statements and service users with 10 statements (Figure 1 and Figure 2).

- An acceptability and feasibility assessment to investigate the use of the MHRS in everyday clinical practice at the end of the study. On a 5-point Likert scale, participants responded to statements about difficulty in completing the MHRS (from 1=very difficult to 5=very easy) and achieved results in a recovery-oriented approach (5-point-Likert scale, from 1=very false to 5=very true). Staff was given 18 and service users 10 (Table 4).

2.2.3 Statistical analysis

Descriptive data were presented as frequencies, means, and standard deviations. Changes between scores on the standardized assessment tools from recruitment to follow-up were examined using the t-test for paired samples correlations. The t-test for repeated measurements was used to analyze the differences in scores between the first and second evaluation. Given the exploratory nature of this study, no correction for multiple tests was conducted.

All tests were bilateral, with a significance level set at 0.05. Statistical analyses were performed using the SPSS 22.0 program.

2.2.4 Power of the study

Although exploratory, for this study we detected a statistically significant improvement in MHRS Scale of Change scores between recruitment and six-month follow-up. Based on a previous study (61), which reported a mean improvement of 0.26 in the MHRS Scale of Change score over 3.5 months, we should

detect a similar improvement with a sample size of 21 participants. Considering a 20% drop-out rate, to ensure sufficient statistical power (80%) with an alpha level of 0.05 and a standard deviation difference of 0.40 or less, we aimed to recruit 25 participants.

2.3 Focus groups

The focus group model was chosen as a qualitative research method to experiment them and explore reactions to the implementation of recovery-oriented practices in the Verona DMH (62). Two focus groups were facilitated by two psychologists and a psychiatry resident. Participants included mental health professionals and trainers of all disciplines and service users. Focus groups aimed to promote the "expert to expert partnership" and shared decision-making process (23,59) between users and professionals, encouraging equal participation.

The first focus group, held from June 2017 to September 2017, consisted of six meetings with an average of 12 participants from the South Verona MHS. This group focused on implementing recovery education and MHRS training.

The second focus group, conducted between January 2018 and May 2018, held eight meetings with an average of 17 participants from the entire Verona DMH. It was focused on strategies to implement the recovery paradigm and establish a collaborative group dedicated to recovery-oriented practices involving both professionals and users.

3. RESULTS

3.1 Service users' socio-demographic and clinical characteristics from baseline to follow-up

As shown in Table 1, at baseline service users were 41.0 (9.9) y.o., mostly male (60.0%), single (76.0%), unemployed (64.0%) and lived in private accommodations (56.0%). Most had a primary diagnosis of Schizophrenia Spectrum Disorder (68.0%) with a mean of 16 years (CI 12.5-19.5) of contact with MHS, an intake of 2.9 (SD 1.6) psychotropic drugs and a mean of 0.3 (0.5) admissions in the acute ward in the previous six months. About a quarter of users presented a concurrent physical comorbidity (32.0%) and a mean of 0.8 (SD 1.1) had a current addiction.

From baseline to follow-up a significant number of service users developed a romantic relationship ($p<0.001$), found a stage/employment/school ($p<0.001$) and increased addictions ($p<0.001$). There was an almost significant reduction in acute ward admission ($p=0.059$) (Table 1).

Table 1 about here

3.2 Recovery Star, functioning, psychopathology, functional autonomy and needs of care from baseline to follow-up

As shown in Table 2, at baseline, most service users, along with their key-professionals, negotiated that they were generally in the Believing phase of the Scale of Change (MHRS, 6.1, SD 5.1). The lowest scores were found in Social networks (MHRS, 5.5, SD 2.2), Work (MHRS, 5.5, SD 2.4), and Relationships (MHRS, 5.5, SD 2.6), which were the main focus of the intervention plans (Table 3). The highest score was observed in Responsibilities (MHRS, 8.1, SD 2.3).

During the follow-up, there was a significant overall improvement in the Scale of Change (MHRS, p=0.003), although services users remained in the Believing phase. Specifically, significant improvements were seen in Physical health and self-care (MHRS, p=0.004), Living skills (MHRS, p=0.012), Work (MHRS, p=0.007), Relationships (MHRS, p=0.018), Responsibilities (MHRS, p=0.050), and Identity and self-esteem (p=0.016) (refer to Table 2).

In the follow-up, among the 20 (80.0%) couples who defined new goals, there was an increase in goals related to Addictive behavior (Table 3).

From baseline to follow-up, users showed improvements in functioning (FPS, p=0.015), psychopathology (HoNOS, p=0.001), and functional autonomy (MPR, p=0.003), with a greater number of met needs (key-professionals CAN ratio from 2.6 to 3.8; service users CAN ratio from 2.8 to 5.2), along with a significant decrease in unmet needs for users (CAN, p=0.026) (see Table 2).

Table 2 about here

Table 3 about here

3.3 Assessing the impact and feasibility of implementing MHRS and a recovery-oriented approach

Figure 2 display the impact assessment of professionals from baseline to follow-up. Positive statements increased overall (from 3.6, SD 0.5 to 3.8, SD 0.4), with significant improvements in statement 9 (‘I feel service users are actively leading in their own recovery’; p=0.036) and statement 11 (‘Our service reflects the needs and aspirations of service users and is enriched by their contributions’; p=0.007). Negative statements decreased (from 4.0, SD 0.6 to 3.8, SD 0.5), indicating overall satisfaction with MHS.

Users also experienced changes from baseline to follow-up. Positive statements decreased overall (from 4.0, SD 0.6 to 3.8, SD 0.5), with a significant decrease in statement 3 (‘Staff make me feel relaxed and welcome and I feel confident to approach them for support’; p=0.038). Negative statements decreased (from 2.4, SD 0.6), compared to baseline (from 2.6, SD 0.7) (Figure 3).

Figure 2 about here

Figure 3 about here

As shown in Table 4 key-professionals found MHRS neither easy nor difficult to complete (3.2, SD 0.4). They reported high availability for meetings and discussions (statement 4: 3.8, SD 0.7) but faced challenges in respecting the intervention plan schedule (statement 6: 2.8, SD 1.0) and fulfilling MHRS

within two weeks (statement 8: 2.9, SD 1.1). Overall, professionals noted that MHRS facilitated a recovery-oriented approach (4.0, SD 0.4), with greater user involvement in project activities (statement 7: 4.4, SD 0.5), but they encountered difficulties in creating collaborations with users (statement 9: 3.7, SD 0.9).

Users found MHRS neither easy nor difficult to complete (3.5, SD 0.4). They expressed comfort in sharing their views with professionals (statement 1: 3.8, SD 0.8) but faced challenges in adhering to the intervention plan schedule (statement 5: 3.0, SD 1.0). Overall, users reported that MHRS facilitated a recovery-oriented approach (4.0, SD 0.5), especially regarding the discovery of hidden personal resources (statement 3: 4.1, SD 0.6) and feeling more involved and accountable in their care path (statement 5: 4.1, SD 0.7). However, they encountered difficulties in improving the trust relationship with professionals (statement 1: 3.9, SD 0.8) (Table 4).

Table 4 about here

3.4 Focus groups

Focus groups showed active participation, with some attendees in both sessions. Participants included current service users, new contacts, and those who returned after dropping out. However, two users had to interrupt due to challenging topics triggering relapse.

In the first group, recovery concepts and MHRS were easily understood. The second group faced difficulties with shared decision making and "expert to expert partnership," challenging traditional roles. Despite this, all topics were successfully addressed, and participants showed interest and comprehension.

Initially, maintaining a balanced discussion was challenging, as some users expressed grievances, and professionals hesitated to share openly. Over time, group strategies and increased trust resolved these issues, fostering respectful exchanges.

The focus groups led to proposals for changing the service culture, including continuous education, professional-user partnerships, and mental health awareness.

3.5 Other results

After the pilot study, the South Verona MHS embraced elements of the recovery approach, using "users" instead of patients and incorporating the MHRS change scale phases. Despite challenges like limited recovery education due to the Sars-cov-2 pandemic and staff turnover, professionals and users emphasized the need for more recovery-focused training, starting with MHRS.

In early 2017, a self-help group formed, uniting users and professionals from different Verona MHSs. They met twice a month, discussing mental health perspectives. The group grew to include 10 users who attended DMH council meetings as listeners. This inspired the idea of transforming the group into an

official users' association named 'The Open Circle'. The association aims to represent users in council meetings, offer peer support training, combat social exclusion, raise mental health awareness, collaborate with professionals, and promote recovery-oriented practices in Verona MHSs. Though not yet officially registered, the group continues to meet, sharing experiences, and fostering co-production and empowerment.

4. DISCUSSION

The main objective of the pilot study was to assess the feasibility, acceptability, and impact of integrating a recovery-oriented approach into the routine clinical practice of an Italian MHS.

The results from the observational study on MHRS indicated that the tool was effective in facilitating and motivating positive changes in users' life dimensions, improving psychopathology, functioning, and functional autonomy. It also helped in identifying users' real needs and reducing the gap between met and unmet needs (47). MHRS was particularly useful in focusing on core areas for targeted rehabilitation projects.

The use of recovery-oriented practices, including MHRS, had a positive impact on professionals and users alike. It improved shared decision making and trust in the relationship between them. However, both key-professionals and service users highlighted challenges in adhering to the time scheduled for intervention plans, indicating the need for more flexible approaches.

The focus groups served as an opportunity to educate further on recovery and experiment with shared decision making through the "expert to expert partnership" between users and professionals. Understanding the recovery-oriented approach positively influenced professionals' attitudes towards users, increasing their satisfaction, motivation, involvement, and empathy in their work (27).

The formation of a user-professional group to discuss and implement recovery, as well as the request for more education on the recovery paradigm, underscored the importance of establishing a common language between professionals and users. This common ground could pave the way for the development of new shared approaches to promote users' personal recovery and support a recovery-oriented re-organization of MHSs (26).

Based on the "10 key organizational challenges" proposed by Shepherd et al. (63) to assess the progress of services in the recovery direction, the South Verona MHS has achieved 3 out of 10 challenges (Increasing "personalization" and choice, Redefining service user involvement, Transforming the workforce).

4.1 Strengths and limitations

This small and exploratory study necessitates caution when interpreting the findings. The pilot involved a limited group of users and professionals from the South Verona MHS, making it non-representative of

the entire service.

Gains observed on the MHRS and other outcome measures could be influenced by natural improvements over time, unrelated to the use of the collaborative tool (regression to the mean effect).

While this pilot represents an opportunity to integrate recovery into the service, no service users were involved in designing the pilot study, which could be seen as a limitation.

Moreover, the multiple testing conducted in the study reduces its statistical power. Therefore, the results only provide an indication of possible effects, and case-controlled studies are required to investigate whether the use of a collaborative tool enhances the effectiveness of the service.

5. CONCLUSIONS

The recovery-oriented pilot study in the South Verona MHS demonstrated the feasibility, acceptability, and positive impact of implementing recovery-oriented practices. As a result, new interactions based on shared decision making between users and professionals have been introduced, and the workforce has embraced recovery concepts, leading to a redefinition of user involvement.

While structural modifications may take time, training professionals and users in the principles of personal recovery-based practice can contribute to refining a new cultural frame and transforming services (29, 64–66). Future projects include focus groups on recovery for users and professionals, MHRS training, and the development of user facilitators and peer experts (67).

Overall, expanding the study to a larger number of subjects could promote greater adoption of these practices and their integration into the service organization. The groundwork has been laid, but further efforts are needed to fully implement and integrate recovery-oriented practices in the MHS.

Abbreviations

MHS Mental Health Service

MHRS Mental Health Recovery Star

FPS Personal and Social Functioning Scale

HoNOS Health of the Nation Outcome Scale

MPR Monitoring of the Path of Rehabilitation

CAN Camberwell Assessment of Need

Declarations

Ethics declaration: ethics approval and consent to participate

All the study procedures comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975 (version 2008): procedures involving patients were approved by the Research Ethics Committee of the University Hospital Trust of Verona (reference 34950, 30/05/2018). Written informed consent was obtained from all patients and mental health professionals.

Clinical trial number: not applicable.

Clinical trial number: not applicable.

Consent for publication

Not applicable.

Availability of data and materials

Requests for original (fully anonymised) participant data may be made to the corresponding author.

Competing interests

The authors declare that they have no conflicts of interest.

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Authors' contributions

AM and MR developed the idea for this study and designed the study. AM, TP, EP and CD obtained the data. DC contributed to the data management. CB conducted the statistical analysis. AM wrote the first draft of the manuscript and all authors reviewed and revised it and agreed the final version.

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Tables

Tables 1 to 4 are available in the Supplementary Files section.

Figures

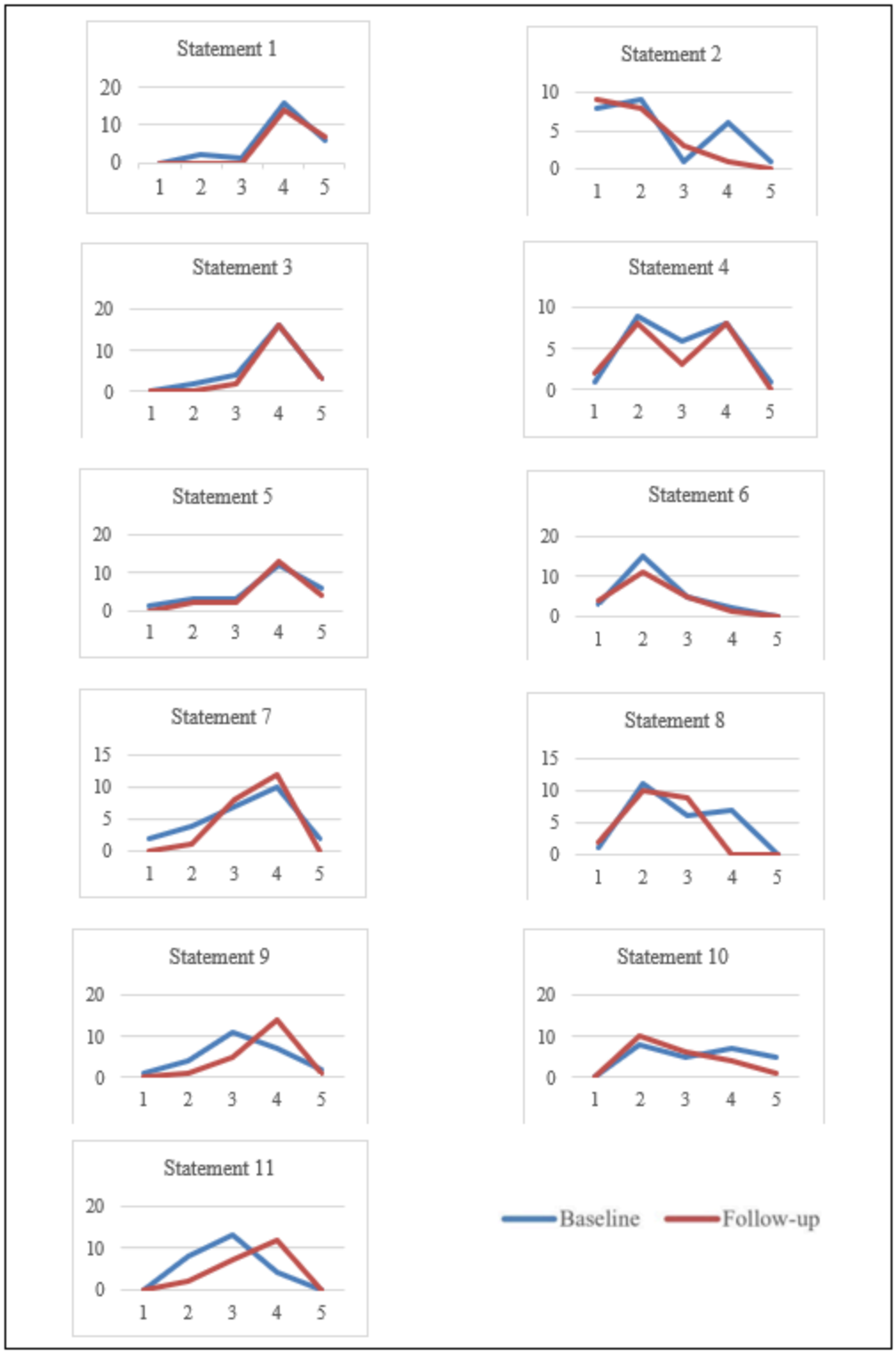

Figure 1

Key-professionals' impact assessment about the recovery implementation in the MHS at Baseline and Follow-up. Statements 1, 3, 5, 7, 9, and 11 were positive, while statements 2, 4, 6, 8, and 10 were negative. Likert scale, 1= Strongly Disagree, 2= Disagree, 3= Neither agree nor disagree, 4= Agree, 5= Strongly Agree

Staff' statements of impact assessments were the following. 1.I feel that service users can clearly communicate their support needs to me; 2. I'm not as motivated as I used to be to encourage positive service user engagement; 3. I feel that I am supporting service users on things that really matter to them; 4. I don't know how much the service users I work with have progressed since they joined the service; 5. Supervision is used to help me think through my key work and support planning; 6. I often feel that I don't know how to communicate with service users about the things that matter to them; 7. I can clearly see and evidence how the support needs of service users have changed in the time I have worked with them; 8. I don't know how the service users I work with feel about the support I provide; 9. I feel service users are actively leading in their own recovery; 10. The impact the work I do has on service users' lives is not picked up by current monitoring methods; 11. Our service reflects the needs and aspirations of service users and it is enriched by their contributions.

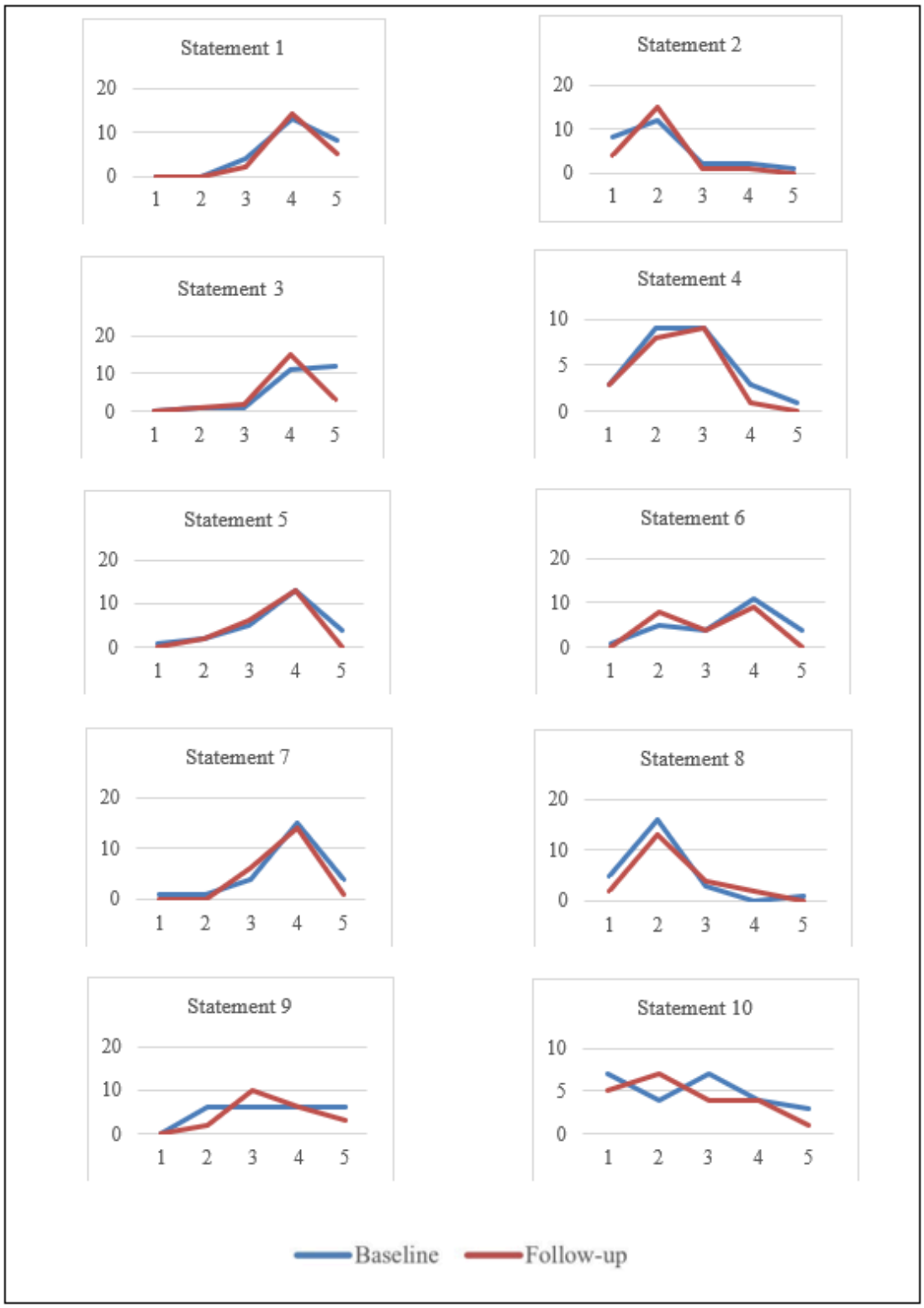

Figure 2

Service users' impact assessment about the recovery implementation in the MHS at Baseline and Follow-up. Statements 1, 3, 5, 7, and 9 were positive statements about the service, whereas statements 2, 4, 6, 8, and 10 were negative. Likert scale, 1= Strongly Disagree, 2= Disagree, 3= Neither agree nor disagree, 4= Agree, 5= Strongly Agree

Service users' statements of impact assessements were the following. 1.I feel listened to when I talk about what support I need; 2.Positive engagement is difficult for me as staff aren't interested in what I want to do; 3:Staff make me feel relaxed and welcome and I feel confident to approach them for support; 4.I don't know how much I've progressed since joining the service; 5.I am made to feel important and that my opinions matter; 6.There are important areas in my life that I don't know how to bring up in key working sessions; 7.I feel satisfied with the advice and support I receive relating to education, training and employment; 8.There aren't enough opportunities to feedback on the support I receive; 9.I feel in control of my life, the decisions I make and the support I get; 10.I feel that I am stuck and don't know what my next step should be

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- TABLE1.docx
- TABLE2.docx
- TABLE3.docx
- TABLE4.docx