Supporting recovery in mental health

Key points

- Changing to more recovery-focused practice in mental health is possible even when resources are limited, but providers will need to review existing services and staffing establishments.

- Joint learning between staff and service users is a powerful and effective approach.

- Good leadership on the ground must have the backing of support at senior (board) level for this approach to mental health recovery to work well.

- People involved in the new approach have been just as keen to learn from their peers as relying on the advice of expert consultants.

The Implementing Recovery Through Organisational Change (ImROC) project is a new approach to helping people with mental health problems that aims to change how the NHS operates so it can focus more on helping those people with their recovery.

The Department of Health commissioned the NHS Confederation's Mental Health Network and the Centre for Mental Health to pilot this major national project involving 29 mental health provider sites from April 2011. This *Briefing* details the interim findings of the project.

Background

In mental health, 'recovery' means the process through which people find ways of living meaningful lives with or without ongoing symptoms of their condition. Users of mental health services have identified three key principles:

- the continuing presence of hope that it is possible to pursue one's personal goals and ambitions

- the need to maintain a sense of control over one's life and one's symptoms

- the importance of having opportunities to build a life 'beyond illness'.[1, 2]

These principles are now central to national mental health policies in England and several other countries including the United States, Canada, Australia and New Zealand.[3]

In England, the recent mental health outcome strategy, *No health without mental health*,[4] contains six key objectives, of which one is "More people with mental health problems will recover".

The document says: "More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social

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relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates, and a suitable and stable place to live."

No health without mental health[4] builds on previous statements supporting recovery as the way forward for mental health services in England[5,6] and has authoritative backing from the Chief Nursing Officer,[7] the Royal College of Psychiatrists[8] as well as most other professional bodies.

The role of mental health professionals (and mental health services) is to try and create the right conditions in which their clients can be supported to lead full and meaningful lives of their choice as part of recovery.

Sometimes contact with mental health services helps achieve these goals, but on those occasions when it does not, the contribution can be restricted to symptomatic relief only, or contact with services can interfere with people getting on with their lives by persuading them to accept reduced expectations or by increasing their sense of dependency.

It is essential that mental health services ensure that the attitudes and behaviour of all staff and teams support the person in their journey and that organisations change to reinforce these processes into changes in policies and practice.

Implementing Recovery through Organisational Change (ImROC)

The ImROC programme came from a desire to address the problem of how to assist services to better support mental health clients' recovery, with a particular emphasis on organisational change issues.

The methodology was developed from a series of workshops held between 2008 and 2010 in five mental health trusts which were aimed at identifying ways in which organisations needed to change to support and maintain practices that were geared towards recovery in mental health clients.

The workshops were attended by more than 300 health and social care professionals, managers and representatives from local independent organisations and were boosted by input from service users and carers.

Ten key organisational challenges were identified (see box below) and a method for implementing these through organisational change was proposed.[9]

This approach was then taken up by the Department of Health and ImROC was commissioned from the Mental Health Network of the NHS Confederation and the Centre for Mental Health to pilot the methodology across a selected number of sites. Health Secretary, Andrew Lansley, and the Care Services Minister, Paul Burstow, formally announced the ImROC programme in February 2011 at the launch of the new mental health strategy.

The programme began in April 2011 and more than 30 mental health providers applied to participate. Each site was required

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Ten key organisational challenges for organisations wishing to support recovery [9]

1. Changing the nature of day-to-day interactions and the quality of experience.
2. Delivering comprehensive, user-led education and training programmes.
3. Establishing a local recovery education college to drive the programmes forward.
4. Ensuring organisational commitment, creating the culture, leadership at all levels.
5. Increasing personalisation and choice.
6. Changing the way we approach risk assessment and management.
7. Redefining user involvement.
8. Transforming the workforce.
9. Supporting staff in their recovery journey.
10. Increasing opportunities for building a life beyond illness.

to demonstrate that they were already working in partnership with local independent providers and could show evidence of good levels of collaboration with local user and carer groups.

Eventually, 29 sites were accepted and were assigned to one of three categories:

· six demonstration sites who were already reasonably well advanced in developing recovery-oriented practices

· six pilot sites who were less advanced, but wanted to progress

· 17 network sites that were just beginning, but were keen to acquire new knowledge and learn from others.

Support for sites

Sites were then offered individually tailored packages of help according to their needs within the limits of the project team capacity and the availability of funding from sites to buy the subsidised package of support.

As planned, the demonstration sites have received relatively less help from the project team. Help has been in the form of joint training and the establishment of key elements of recovery-oriented practice, such as peer support workers.

The pilot sites have received the most help in the form of expert consultancy to help them review services using the organisational challenge framework, set goals for change, agree on progress indicators, implementation and review.

This has also involved advice on the management infrastructure needed to deliver the project locally – such as advice on composition and operation of the local project team and senior management support – as well a help to ensure organisational commitment.

The pilot sites have also received expert advice on how to establish certain key elements of recovery-oriented practice, including recruitment, training, placement and support for paid peer support workers in clinical teams[10] and the development of local recovery colleges[11] – study and training facilities that provide a range of courses and resources for service users, families, friends, carers and staff with the aim of supporting people to become experts in their own self care and for families, friends, carers and staff to better understand mental health conditions and support people in their recovery.

Along with the demonstrator and pilot sites, the network sites have attended learning set events – one-day workshops held over two years.

Training

Most of the sites began with training events for staff to introduce them to the basic principles of recovery for mental health clients.

The content of these sessions were worked out jointly by members of the project team and a small group of expert peer trainers.

The courses were delivered on-site to mixed audiences of local staff and service users and parallel

events were also held for team managers and key clinical leaders (psychiatrists, psychologists, professional leads). If necessary, these were supported by similar sessions for board members.

This combination of training for front-line staff, plus training for key managers and clinicians was deemed necessary to ensure that organisational change occurred from the bottom up and the top down.

The aim was also to train local staff and service users to deliver these courses after the project team had left, thus building their capacity and leaving a lasting legacy.

Learning

In addition, all sites have participated in a themed learning set consisting of six one-day workshops to be held over two years.

Each learning set group comprises of up to eight sites – of all types – sending as many as eight people to attend.

The topics for each workshop are shown in the box on page 4.

Each workshop involved a formal presentation by an expert on the topic, followed by a practical example of good practice from one of the sites and then listening to users' comments and discussions.

The ImROC project organisers say the events have promoted joint learning with a real sense of staff and service users working together to solve common problems.

Topics for the learning sets

The organisational journey
- How did the organisation get to where it is today?
- What has been learned about problems in facilitating change in the future?

Staff and servicer users learning together
- How can staff and service users work together to plan and deliver training to mixed audiences of staff and service users?
- How to train and support staff and service users to do this.
- How to recruit, train and employ peer support workers.

Personalisation, choice and personal budgets
- How can we ensure that services are made more personalised using social care direct budgets and personal health budgets?
- How can we get over the bureaucracy and produce simple, effective systems?
- What are the limits of personal budgets?

Creating a recovery college
- What is a recovery college?
- How can we set up local recovery colleges?
- How can we develop the curriculum and ensure that it is delivered trust-wide?

Risk and safety
- How can we reconcile the principles of recovery with responsible risk assessment and management planning?

Building a life beyond illness
- How can we help service users into paid employment?
- What can we do to assist people find and keep housing of their choice?
- Developing social support and community integration.

What has been achieved?

To date, members of the project team have undertaken 75 visits to the sites, mostly by ImROC consultants and ImROC peer trainers.

They found that in most cases, local sites had strong links with local service user and carer groups to support planning and implementation of recovery-focused practice.

In addition, 16 of the one-day learning set workshops have taken place, attended by 751 people, including 101 service users and/or carers.

These workshops have been positively evaluated and there was consistent evidence demonstrating that delegates were able to pick up the key points of the day and take this knowledge back to their organisations.

Quotes from workshop attendees:

"I found the learning set really motivating and love hearing what others are up to and sharing ideas"

"I learnt that everyone is on a journey and each site is at a different stage – and this is ok"

"My top priority after the learning set is to go back (to my organisation) with information and learning and discuss with my team – change will occur in our service!"

Solutions

In terms of local changes to services on the ground, data from the 12 pilot and demonstration sites shows they have chosen to focus on:

- Training to change attitudes and behaviour of front-line staff and similar sessions for team managers and key professional leaders to support these changes – More than 70 courses have been delivered across the sites to approximately 750 staff and service users.

- Establishing Recovery Colleges – Three are already open and four more are planned by the end of the year – all without significant extra resources.

- Recruiting, training, employing and managing peer support workers – More than 120 peer support workers are now employed (mainly part-time) across seven sites.

- **Improving local policies for risk assessment and management planning** – Five sites have undertaken major reviews of their current risk assessment and management procedures and are beginning implementation. Four more sites are set to follow.

- **Increasing personalisation and choice** – Three sites have completed major reviews of their procedures for individual care planning and seven have made significant progress with implementation of personal budgets.

- **Increasing opportunities for a life beyond illness** – Four sites have already well-established Individual Placement and Support (IPS) services and four are planning to do so.

- **Improving methods of outcome measurement** – Several sites had already used tools like WRAP (Wellness Recovery Action Planning) and the Recovery STAR to assist with care planning, but these are not really suited as outcome measures.[12] Eight sites are planning to use the new INSPIRE tool developed by Mike Slade and Julie Williams as part of the REFOCUS project[13] and four are already collecting data.

Key learning points

The project organisers have identified a number of key learning points.

Getting started

There is no single blueprint for implementing recovery-focused practice – There were large variations from one organisation to another both in terms of their state of readiness to adapt to recovery-focused practice and the ways in which they were able to capitalise on the opportunities of ImROC. There was also considerable variability in local situations in terms of the availability of resources and the willingness of local user-led organisations to embrace joint working.

It is easier to build where you already have good foundations – The amount (and speed) of service change is influenced by where an organisation is starting from. Some organisations had already made significant progress in implementing a recovery-oriented service before the project began and had a recovery strategy for mental health adopted by the Board, undertaken relevant training and had well-developed systems for service user involvement. Other organisations took more time to make progress.

Training of front-line staff on its own is not sufficient and teams are important – Almost all the sites are engaged in recovery training for staff. This is clearly most effective when it is co-delivered by staff and service users together and when it is run along recovery principles such as recognising and building on existing strengths, acknowledging the concerns and goals of participants, and not being too prescriptive. However, it is also clear that staff will only change their practice when the whole team and the whole organisation is committed.

For change to occur it requires good leadership on the ground combined with support at senior level – On every site, the importance of having a good project team was evident with a competent, well-organised approach and good project management skills. It also needs to combine clinical credibility with an ability to represent the project at a Board level. At Board level, there needs to be strong support from executive and non-executive directors.

The action plans need to demonstrate a willingness to take on some of the hard problems, together with some easy wins – If the move towards a more recovery-oriented service is to be credible, there needs to be a willingness to address some of the more difficult problems of organisation and delivery that it faces – such as reconciling a recovery-oriented approach with current procedures for risk assessment and management or the demands of Care Programme Approach. In contrast, helping teams review their practice according to recovery principles or ensuring that every patient has their own Personal Recovery Plan, are more easy objectives.

The process of change

It takes time – Changing organisations always takes longer than expected, due in part to other pressures on the NHS such as service reconfigurations arising from current budget restrictions. It also takes time to set up the appropriate management structures for the ImROC project and to ensure that these are integrated into the ongoing management processes within the organisation. There is also often initial resistance to different ways of working.

> 'Supporting recovery effectively means making fundamental changes to the organisation, priorities and practices of mental health services'

There is a willingness to share knowledge and experience and to learn from others – Historically, mental health services have often progressed most by learning from the example of others rather than from top-down policy implementation. In the learning set workshops, there have been many examples of successful collaborative learning.

The demand for on site consultancy support has been less than expected – Sites have tended to request support and advice on a more ad hoc basis such as via email or telephone, as issues have emerged. There has also been strong ownership of the change programme by the sites themselves. The learning set workshops have facilitated peer learning and networking between the sites and several of the demonstration sites have also offered demonstration days where other sites visit their organisation and attend a full-day workshop which have been popular.

The project has demonstrated the power and influence of joint learning between staff and service users – The project has demonstrated how much can be achieved if staff are prepared to relinquish some of their power and to collaborate with service users on an equal basis to address topics of organisational change.

A small number of key changes in practice seem to be necessary, but not sufficient, conditions for more recovery-oriented services – The project's organisers found that a relatively small number of elements seem to be critical for changing practice and moving the organisational culture towards a more recovery-oriented approach. These include development of existing staff and teams through delivery of co-produced training; selection, training, placement and support of peer workers in practice, teaching, administration and research posts; and the establishment of local recovery colleges.

For the future

The Ten Key Challenges have proved to be a useful core framework for the project – Participating organisations have found the Ten Key Challenges to be a useful way of helping local services review their individual and organisational practices in relation to supporting recovery and set goals for change. There are, however, limitations to the framework regarding the needs of carers and the people from black and minority ethnic groups. The project organisers intend to review the framework at the end of the project and consider if any major alterations are needed.

We lack evidence for effectiveness – A sound and well-defined outcome framework for recovery needs to include improved quality of experience, enhanced subjective perceptions of hope and control, and the achievement of personally relevant life goals (such as stable and secure housing, employment, networks of social support). The project organisers believe it will be some time before this kind of framework is accepted by all providers and commissioners. It will also take time before routine measurement systems are in place to capture this kind of information. They plan to work with the Department of Health on measuring mental health outcomes.

Although some of the most advanced services have moved towards supporting recovery more effectively, they have hit fundamental barriers to do with lack of resources and traditional practices – Some of the most advanced sites have come up against problems such as lack of resources and traditional ways of working. Supporting recovery effectively means making fundamental changes to the organisation, priorities and practices of mental health services. If concepts like recovery colleges and peer support workers are to become the norm, the NHS will need to provide capacity and, in the current climate, this means reviewing existing services and staffing establishments. The project organisers believe a 'big bang' is now imminent and that services will have to undertake major staffing reconfigurations in order to deliver more recovery-oriented services.

Change is still possible, even in the current economic climate – The current economic climate has been a difficult one in which to mount a programme of major organisational change. However, for many sites the value of this new approach of focusing on mental health clients' recovery

seems to have trumped these resource constraints. By doing this in genuine partnership with service users and other community organisations the burden of these external pressures have been shared and helped managers. The project organisers believe the programme provides an important lesson that change is possible, even when resources are limited, providing that all the key stakeholders are prepared to work together

change. This could form the basis of a commissioning framework. It depends on changing basic, everyday interactions between staff, service users and carers and this will involve a review of internal rules and procedures, priorities, workforce and the range of services available. Most importantly, it involves offering people who have lived experience of using mental health services a range of opportunities to contribute to their operations. Taken together these constitute a fundamental rethink

of the structure of mental health services. It is certainly an ambitious agenda, but it can be addressed, even in these difficult economic times, if staff and service users work together and all levels of the organisation are committed to change. Perhaps what we need most of all at the present time is a clear and simple set of outcome measures to guide this process.

For more information on the issues covered in this *Briefing*, contact ?????????

Mental Health Network viewpoint

We conclude that the principles of recovery can be operationalised and that it is possible to generate a list of quality indicators that define an agenda for organisational

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Demonstration sites

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- Dorset Wellbeing & Recovery Partnership.
- Hertfordshire Partnership NHS Foundation Trust.
- Manchester Mental Health & Social Care Trust.
- Nottingham University Hospitals NHS Foundation Trust.
- South West London and St George's Mental Health NHS Trust.

Pilot sites

- Central and North West London NHS Foundation Trust.
- Devon Partnership NHS Trust.
- Southern Health NHS Foundation Trust.
- Mersey Care NHS Trust.
- St Andrew's Healthcare.
- West London Mental Health NHS Trust.

Network sites

- Avon & Wiltshire (Fromeside).
- Cardiff & Vale University Health Board.
- Care UK.
- Cheshire & Wirral Partnership NHS Foundation Trust.
- County Mayo Mental Health Services.
- Coventry & Warwickshire NHS Partnership Trust.
- East London NHS Foundation Trust.
- Herefordshire partnership NHS Foundation Trust.
- 5 Boroughs Partnership NHS Foundation Trust.
- Kent & Medway NHS & Social Care Partnership Trust.
- Norfolk & Waveney Mental Health Foundation Trust.
- Northamptonshire Healthcare NHS Foundation Trust.
- Nottinghamshire NHS Forensic Services.
- South Essex Partnership Trust.
- Worcestershire Mental Health NHS Partnership Trust.

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The Mental Health Network

The NHS Confederation's Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors.

The MHN works with government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

For further details about the work of the MHN, visit **www.nhsconfed.org/mhn** or email **mentalhealthnetwork@nhsconfed.org**

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