

Paris Conference – Lifelong Learning and Empowerment in Mental Health. 11 February 2010

Making Recovery a Reality. Challenges for Recovery- Orientated Mental Health Services

Jed Boardman

Today I would like to talk about a development project that we have been carrying out at the Sainsbury Centre for Mental Health to look at ways in which we can make our mental health services more 'recovery-orientated'

Geoff Shepherd (who will be speaking later) and I devised and led the project.

Why are we interested in Recovery?

Our primary interest was in taking the principles and concepts of Recovery and to look at ways in which our practices and services could be orientated to facilitate Recovery in people who use mental health services

We are aware that there has been a developing body of literature on the research evidence for the value of Recovery principles (particularly optimism about outcome about psychoses, the value of empowerment and of productive roles such as employment). But there is also the vast literature on the experience of service users and their own accounts of their journeys, their experiences of mental health services and what they require from these services, that we can tap into.

We were also aware of the opportunity afforded to such developments by current mental health policy, not only in the UK, but also in other countries. There has also been support in the UK from the main mental health professional organisations, including the Royal College of Psychiatrists, College of Occupational Therapists, British Psychological Society and the Royal College of Nursing.

In the UK in the last 10 years, Mental Health Policy and General Health Policy has supported the ideas of Recovery and the latest policy document on Mental Health from the Department of Health, *New Horizons*, has placed Recovery in a central position in future developments.

But – in looking at mental health services in the UK, we have also realised that whilst there are examples of good practice in this area in many parts of the UK, many mental health service providers had made little progress in this area and there was no clear guidance or consensus or strategy as to how we might develop comprehensive services which are based on Recovery principles.

The problems of implementation

One matter that prompted us to become concerned with this area was the often heard statement from fellow workers and others in mental health services that they were now “doing Recovery”. It is clear that professionals do not “do Recovery” and Recovery cannot be implemented by services.

Recovery ideas have been formulated by and for service users to describe their own experiences. It is service users that “do Recovery”.

But professionals (and mental health services) can influence Recovery and Recovery journeys – they can impede them (as has often been the case) but they can also facilitate them – and this idea of the facilitation of Recovery is a central point in our thinking.

If recovery ideas are to have an impact then professionals and others working in mental health services need to understand what recovery means and, in partnership with service users and others, actively support their implementation across services.

This requires giving attention to changing the way we work, changing the structure and the culture of our organisations to be ‘recovery-orientated’.

The Sainsbury Centre Project wished to examine what we need to do to achieve this – How can we put the ideas of Recovery into practice - What are the challenges to this?

The Sainsbury Centre Project: ‘Supporting Recovery’

For the project we assembled a Steering Group representing 5 NHS provider Trusts and their local partners who had already made significant progress towards implementing more ‘recovery-oriented’ practices. It consisted in clinical experts in this field, service users and people from the major mental health charities.

We produced an initial Briefing paper ‘*Making Recovery a Reality*’ (SCMH, 2008) summarising the key principles and how these link to practices and services – we also looked at the common objections to Recovery - and some of the possible problems of implementation.

We then ran a series of local workshops in the NHS Trusts, each examining a different area of **organisational change** that we thought necessary to address in order to move towards more ‘recovery-oriented’ services.

The output of these workshops was published as a short document – *Implementing Recovery. A new framework for organisational change* in which we set out 10 challenges for organisation change which I will talk about later.

What I will now cover is:

- Our summary of the main principles of Recovery that directed our thinking
- A brief discussion on how we might change our practice
- The challenges that we need to address in order to change towards recovery-orientated services
- A brief mention of the next stage of the project – how we might address organisational change

Recovery – a definition

We used Bill Anthony's definition of Recovery as the starting point – this may be paraphrased as 'living a life beyond illness':

"... a deeply personal, unique process of changing one's attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

(Anthony, 1993)

Recovery – summary

In summary we considered Recovery to be concerned with:

Recovering your life and building a meaningful life 'beyond illness', based on self-defined goals, not the 'realistic' expectations' of professionals.

The core principles which found to give a useful summary of Recovery were:

Hope - the need always to maintain hope

Agency (control) - An emphasis on **re-discovering a sense of personal 'agency'** and control - over symptoms and personal goals

Opportunity – this links Recovery to social inclusion and the importance of participation in communities and wider society. This emphasises such things as the importance of **informal supports and natural social networks** – friends, community activities, clubs, churches, etc., in addition to formal help from services

What are the implications for MH services?

Using the definition and the 3 basic principles we can link these to the implications for mental health services.

We already know that we can be more optimistic about the outcomes of psychoses and that empowerment of people with mental health problems improves outcomes. But there needs to be a focus on services in which decisions are taken collaboratively with service users and services which aim to assist people with mental health problems into productive roles.

There needs to be:

- Increased awareness of the impact of practices and procedures on peoples' sense of control.
- Importance of encouraging the person to find their own *meaning* in events (not simple 'psycho-education')
- Explicit attempt to reduce the traditional power differences between those using the service and those providing it
- Recognition of the value of 'experts-by-experience'.
- Emphasis on *social goals*, rather than *clinical outcomes*
- Redefinition of professional roles – '*on tap, not on top*' (borrowed from Winston Churchill)
- Professionals as the 'carriers of hope'

Practice, Services and Culture

From the workshops we identified that there needs to be changes in:

- Practice – staff and professional training
- Service Organisation and Delivery
- Culture of Services

These areas of change are not independent of each other and the three areas should be addressed in parallel.

It is a given here that our practices and services and the things they deliver are based on the best available evidence.

Recovery – Role of Professionals

This may be the subject of another lecture – but the basic changes need to be:

A shift in the relationship to one emphasising partnership – along the lines of that between a *coach*, and an *expert by experience*

A shift away from 'doing to' to the provision of resources, self management – professions being seen as *on tap, not on top*

The provision of hope – which is realistic and pragmatic

A shift in the central objectives to social and valued outcomes, which include housing, employment, education, participation in mainstream community and leisure activities

Ten Top Tips for recovery oriented practice

We put together these '10 top tips' and have found these tips for practice useful in getting the practice changes over to professionals – these have been readily taken up by colleagues and can be use for training.

After each interaction, ask yourself did I...

1. *actively listen to help the person make sense of their mental health problems?*
2. *help the person identify and prioritise their personal goals for recovery – not my professional goals?*

3. *demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?*
4. *identify examples from my own 'lived experience', or that of other service users, which inspires and validates their hopes?*
5. *pay particular attention to the importance of goals which take the person out of the 'sick role' and enable them actively to contribute to the lives of others?*
6. *identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of their goals?*
7. *encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)?*
8. *discuss what the person wants in terms of therapeutic interventions, e.g. psychological treatments, alternative therapies, joint crisis planning, etc., respecting their wishes wherever possible?*
9. *behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to 'go the extra mile'?*
10. *while accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations?*

Let us now move to some of the organisational changes that will be necessary. All of these are based on the output from the workshops and from our review of the literature.

The dimensions of recovery - changing experience, changing values

We believe that the ideas of Recovery must go right through the organisation – influencing it at every level.

First and foremost there needs to be a fundamental **change in the quality of day-to-day interactions**. Every interaction, by every member of staff, should confirm recovery principles and promote recovery values.

This means introducing comprehensive, **user-led education and training programmes** for *all staff, across all professions* and at *all levels*.

This requires a supply of **trained – and supported - service users to act as the 'champions of change'**.

To provide this, we suggest the creation of a '**Recovery Education Unit**' in each Trust, run by user-educators, linked to the Trust's development strategy and to local education providers (to ensure standards)

The dimensions of recovery - changing the 'culture'

But, **training will not be enough**

Recovery values need to become **embedded into every management process**: recruitment, supervision, management and appraisal, operational policies, etc.

Even 'mission statements', 'straplines', language, etc.

This means **leadership** 'from the top', combined with the effective use of information

The effects on practice

A greater emphasis on recovery should then lead to increased '**personalisation**' (individualisation of care): greater shared decision-making (e.g. regarding treatments); use of individual budgets, etc.

Changed procedures for **risk assessment and management** - more open, transparent, more involved

..... and a redefinition of '**user involvement**' - based on **partnership**, rather than 'involvement'.

Effects on the workforce

We believe that this will lead to a fundamental review of **skill-mix and professional/user 'balance'** within the workforce.

We suggest that we should consider a **radical transformation**, aiming for perhaps 50% of care delivery by appropriately trained and supported '**peer specialists**'

This has obvious implications for Human Resource and Occupational Health Departments, but is entirely consistent with the demands of government schemes for employment (eg PSA 16) and the requirements of Disability Discrimination legislation (DDA).

We will also need to **support staff (and carers) in their recovery journeys**; valuing their 'lived experience' and the contribution that this can make to their professional roles

Effects on the 'system'

Finally, it means **opening up the organisation**, turning it around to be 'outward' – instead of 'inward' - facing.

Developing its partnerships with non-mental health agencies, particularly housing and employment, so that these become the central focus, not secondary 'add-ons'.

Supporting people using the service to build a life '*beyond illness*'.....

..... and to achieve not just '*integration*' in the community, but also '**inclusion**' within it.

Summary

These points can be summarised as our *10 Key challenges for organisational change*:

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 'Recovery Education Unit' to drive the programmes forward
4. Ensuring organisational commitment, creating the 'culture'
5. Increasing 'personalisation' and choice
6. Transforming the workforce
7. Changing the way we approach risk assessment and management
8. Redefining user involvement
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life '*beyond illness*'

Developing the approach - Organisational change

These key challenges can provide a starting point for organisational development – We have the main headings for a 10-point plan to develop a Recovery-orientated organisation.

We need to test this out – and we will begin a new project later this year in 6 NHS Mental Health provider organisations. This project is supported by the Department of Health, The National Mental Health Development unit and the NHS confederation.

We have produced a methodology to support this which we will publish later this year. The methodology is designed to assist organisational change and Commissioning – to 'co-produce' system change, and improve process and outcomes.

The methodology aims to create a constructive process of 'co-production' between local providers and commissioners, in partnership with service users and carers, which aims to transform services through the development of the jointly agreed key areas of recovery-oriented practice (the 10 Organisational Challenges). We believe that a key element driving this transformation will be the joint work of local systems, setting priorities, agreeing goals and contracts and then moving the process forward.

In this process we need to avoid being too rigid and formulaic as this runs the risk of locking local providers and commissioners into a rigid view of how, what are essentially innovative developments, should proceed.

We believe that our approach offers a flexible means of delivering organisational change towards more recovery-orientated services.

But it will be important to have leadership and organisational commitment to effect these changes.

We are suggesting a simple 2 phase process:

Phase 1 – Developing the ‘vision’ and benchmarking.

We should be able to rate the organisation on each of the 10 challenges on their stages of progression:

Engagement - The organisation is clearly engaged in its intent to deliver recovery oriented services. Plans are made but little process yet.

Development - Action is being taken with some evidence of significant developments in practice, policy and culture. Good progress is being made in delivering recovery oriented services in some areas, but this is not consistent throughout the organisation.

Transformation - The vision for achieving significant change has been fully realised. The necessary policy, processes and practice to deliver a recovery orientated service is embedded at every level of the organisation. There are processes in place to achieve continuous improvements based on learning from ongoing review.

Phase 2 – Developing the strategy, monitoring and review

We would see this occurring in the form of internal audit loop (or ‘Plan-Do-Study-Act’ cycle) – an effective process for producing sustained organisational change.

We would ask that they choose a few of the challenges to develop and add others over time.

To assist with setting and monitoring specific targets, we developed a template for each challenge which shows examples of service level indicators and potential data sources for each of the organisational challenges.

The methodology described here attempts to describe a constructive process of ‘co-production’ between local providers and commissioners, in partnership with service users and carers, which aims to transform services through the development of the jointly agreed key areas of recovery-oriented practice. We believe that a key element driving this transformation will be the joint work of local systems, setting priorities, agreeing goals and contracts and then moving the process forward.

We believe we need to avoid being too rigid and formulaic as this runs the risk of locking local providers and commissioners into a rigid view of how, what are essentially innovative developments, should proceed.

We believe that our approach offers a flexible means of delivering organisational change towards more recovery-orientated services.