Implementing Recovery in Mental Health Services – What can we learn from the UK experience?

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Dr. Jed Boardman, Consultant Psychiatrist, South London & Maudsley NHS Trust

&

Professor Geoff Shepherd, Recovery Programme lead, Centre for Mental Health, London
How does Recovery fit into Mental Health Services?

Jed Boardman
UK Mental Health Services - *From Asylum to Community*
The need for some new ideas about practice

Community mental health services across England – generally good structures

But - what about the content and quality?

- Are they too symptom focussed?
- Do they pay sufficient attention to the goals of people who use them?
- Do they pay sufficient attention to social outcomes? - somewhere decent to live, a job, some money and social relationships?
- What is the position of service users?
- Do we pay sufficient notice to carers?
What is Recovery?

- Living a life beyond illness

- ‘Recovering your life’ – building a meaningful life ‘beyond illness’, based on self-defined goals, not the ‘realistic’ expectations’ of professionals (e.g. employment)
What is Recovery?

Key ideas

- **Clinical recovery and Social Recovery**
  
  “*We define recovery as achieving the life we want in the presence or absence of mental distress.*”
  
  Mental Health Foundation of New Zealand (2008)

- **Recovery is a process**

- **And a Civil Rights movement**
What is Recovery?

Key elements

- Ideas of Recovery come from service users stories

- Key elements:
  - Hope
  - Control
  - Opportunity

Centre for Mental Health
Recovery is impossible without hope...

If you can’t see the possibility of a decent future for yourself – what is the point in trying?

Relationships are central to hope:

- It is difficult to believe in yourself if everyone around you thinks you will never amount to very much
- When you find it hard to believe in yourself you need others to believe in you
Recovery involves taking control over your own problems, life and destiny ...

Control over:

- The way you understand what has happened to you
- Your problems and the help you receive
- What you do in your life
- Your dreams and ambitions
Recovery is impossible without opportunity

Social inclusion is important for recovery:

- Being a part of our communities – not apart from them
- Being a valued member of those communities
- Having access to the opportunities that exist in those communities
- Having the opportunity to contribute to those communities
“Two or three years ago I realised that you really could recover.... I thought that once you had it, that was it – but you can recover. I find that quite an amazing fact....”

“...I have taken ownership of my illness and I take responsibility for what I do and do not do. I don’t let it control me......It’s not the whole of my life, it’s just a part of my life now....”

“...The hardest thing about having a mental illness is the feeling that you’re constantly taking, that people are always giving to you, that people are always supporting you.....Recovery has been about actually looking at ways I can give back to other people that I care about...”

(from Brown and Kandirikiriria, 2007, Scottish Recovery Network)
‘Recovery’ refers to a set of narratives (stories) written by individuals living with mental distress about their lives. These are their stories and only they can make ‘recovery’ happen.

Recovery is therefore not a new method of ‘treatment’. Staff can’t make people recover.

Professionals and services can (and do) influence these stories - sometimes helpfully, sometimes unhelpfully.

Recovery-orientated practice and services

Significant changes to practice, services and culture in order to be more supportive of recovery processes.
1. Assembled a Steering Group representing 5 NHS Trusts and their local partners who had already made significant progress towards implementing more ‘recovery-oriented’ practices.

2. Produced an initial Briefing paper ‘Making Recovery a Reality’ (SCMH, 2008) summarising the key principles - and the common objections - and raising some of the implementation problems.

3. Ran a series of local workshops, each addressing a different area of **organisational change** deemed necessary in order to move towards more ‘recovery-oriented’ services.
Support and resistance to the project

- Government Policy
- Professionals
- Service users and families
- Organisations (managers)
Mental Health policy and Recovery

Two strands:

- Changing demands and expectations - Consumerism, individualism
  - Personalisation
  - Chronic Disease management
  - ‘Expert patients’
  - Self care
  - *New Horizons* (2009); *No Health without Mental Health* (2011)

- Reducing ‘social exclusion’
Current Mental Health Policy (Department of Health, 2011)

No health without mental health

A cross-government mental health outcomes strategy for people of all ages
Key objective (Number 2)

More people with mental health problems will recover

“More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social 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”
Professional support and resistance

Most professional bodies now support Recovery ideas
- Royal College of Nursing
- College of Occupational Therapy
- British Psychological Society
- Royal College of Psychiatrists
- Social Work

But there is still some resistance from some professionals ‘on the ground’
Support from the Royal College of Psychiatrists

A common purpose:
Recovery in future mental health services

Recovery is for All
Hope, Agency and Opportunity in Psychiatry

A Position Statement by Consultant Psychiatrists

December 2010
Fits in with other RCPsych policies
Support and resistance from service users and families

- Anxieties about change

- Professionals influence. Some users accept this – and some don’t!

- We still haven’t fully identified the contribution of carers and families (but we are working on it!)
From the beginning, many managers said, ‘All this sounds OK, but what does it really mean? How can we tell if we are doing it or not?’

We recognised this and have spent a lot of time on trying to clearly formulate and describe the organisational implications of ‘Recovery-oriented’ services.

As part of this we have worked closely with the staff organisation that represents senior managers in mental health services (the ‘NHS Confederation’ MH network).
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2. Produced an initial Briefing paper ‘Making Recovery a Reality’ (SCMH, 2008) summarising the key principles - and the common objections - and raising some of the implementation problems.

3. Ran a series of local workshops, each addressing a different area of organisational change deemed necessary in order to move towards more ‘recovery-oriented’ services.

4. ....... and formulated a list of the ‘10 key Organisational Challenges’ to moving towards more Recovery-oriented services
Summary - Key organisational challenges (SCMH, 2009)

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’ (e.g. IPS)
Supporting Recovery through organisational change

Come on! It can't go wrong every time...

Geoff Shepherd
In order to implement more ‘recovery-oriented’ services, we need to make significant changes to practice, services and culture.

This will require leadership – at all levels - and changes to organisational culture

We also have to consider radically adjusting the composition and skill-mix of the workforce
Changes to practice, how can we ensure that every interaction ........

☑ Supports service users in the pursuit of their personal life goals, maintaining a consistent belief that they are possible

☑ Builds on their strengths, rather than listing their problems

☑ Respects their knowledge and expertise as different, but valued

☑ Uses educational approaches, as well as therapeutic models

☑ Increases their opportunities for employment, education and community integration – using existing networks wherever possible

Implications for training

- These changes to practice will require **user-led education programmes ‘co-delivered’** for all staff, across all professions, at all levels.

- Staff and users should have the opportunity to learn **together**.

- They should also have **regular opportunities** to reflect on practice and celebrate success.

- We suggest that this is best achieved by establishing a ‘**Recovery College**’ on each site, jointly run by service user trainers and staff, offering courses on Recovery and living with mental health problems.

- **But, training will not be enough on its own.**
Whitely et al. (2009) studied implementation of Mueser’s ‘Illness Management and Recovery Programmes’ across 12 community settings, highlighted importance of:

- training
- supervision
- leadership
- culture of innovation

Where present together acted synergistically

But training on its own was ineffective

Hence, the need to change the organisation and its values
Changing the organisational culture

- **Policies and procedures** – ‘Our values live in the organisational infrastructure’ (Farkas, 2010). Hence, we need to re-evaluate:
  - referral processes
  - assessment and care planning (e.g. WRAP)
  - record-keeping
  - risk assessment and management policies

- **Recruitment and staff selection** – What characteristics are you looking for in ‘Recovery-oriented’ staff? ‘Humanity’ v. ‘technical competence’

- **Staff management and appraisal** – Is information collected from service users regarding staff performance? (‘360 degree’ appraisal). Do we reward staff who are rated highly by service users?
A radical change to the workforce

Just how many mental health professionals does it actually take to run a mental health service?

*Rachel Perkins, OBE (2008)*

Director of Recovery, SW London & St. George’s, NHS Mental Health Trust
We believe that there should be a fundamental review of skill-mix and professional/user ‘balance’ within the workforce.

We should consider a radical transformation, aiming for perhaps 50% of care delivery by appropriately trained and supported ‘peer specialists’.

In addition to training, they must also be supervised and supported – and have opportunities for career progression. It won’t be easy!

We also need to support staff in their recovery journeys, and demonstrate that we value their ‘lived experience’ and the contribution that this can make to their professional roles.
So, how might this be achieved?
A methodology for organisational change
‘10 Key organisational challenges’

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user-led education and training programmes
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Implementing Recovery - Organisational Change (ImROC)

Geoff Shepherd, Jed Boardman, Rachel Perkins & Julie Repper

A 3 year project funded by the Department of Health and delivered through a partnership between the Centre for Mental Health and the MH Network of the NHS Confederation
The ImROC programme

- Began in April 2010, 30 sites have now been selected to take part in the programme:
  - ‘Demonstration sites’ (n=6)
  - ‘Pilot sites’ (n=6)
  - ‘Network sites’ (n=18)

- Different sites receive different levels of intervention, depending on their needs

- All sites have the opportunity to send 6-8 people to local ‘Learning Sets’ (x6 over 2yrs.) to meet together and share ideas for change
ImROC sites

Centre for Mental Health

- Demonstration Sites
- Pilot Sites
- Network Sites
- County Mayo (NW Ireland)
- Care UK - nationwide
Progress so far

- All the initial assessments have been completed and development plans drawn up. Most common target areas are:
  - Developing local capacity to deliver user/staff learning events on Recovery
  - Plans to establish local ‘Recovery Colleges’
  - Work to inform senior managers in organisations (Board level) + key clinical leaders (psychiatrists, psychologists, professional leads)
  - Work to review key policies and procedures (individual care plans, risk assessment, etc.)
  - Developing training for ‘peer specialists’
  - Addressing the ‘Recovery Needs’ of carers
Some examples of Recovery ‘in action’
One of London’s major MH providers, employs more than 2500 staff, treats 40,000 people/yr. and is in active contact with 20,000 people at any one time.

Almost all staff have attended ‘co-led’ introductory sessions on Recovery and more than 700 have attended a 4 day ‘Recovery and Social Inclusion’ workshop.

At any one time, 80-90 people with lived experience working in the Trust and around 20% of new recruits to professional positions declare that they have experienced mental health problems themselves.

25 IPS-trained ‘Employment Specialists’ embedded in teams who place more than 300 people a year in paid employment.

The Trust recently has established the first UK ‘Recovery College’ employing 5 peer trainers.
The Wellbeing and Recovery Partnership (WaRP)
Becky Aldridge, General Manager
Dorset Mental Health Forum
Achievements ….

✓ Dorset Mental Health Forum is now established as a valued partner with the NHS Trust at all levels of planning, service development and quality improvement

✓ More than 60 people from the Mental Health Forum are now employed in a variety of staff positions in the Trust

✓ Service users involved as ‘mentors’ for consultant psychiatrists

✓ The ‘Hidden Talents’ programme has offered support for staff who are prepared to disclose their own histories of mental distress
What have we learned?
Recovery means a new relationship between ‘them’ and ‘us’

A true partnership

Based on a recognition of our common humanity and what unites us, rather than what divides us
And the future?

- No new money means we will have to make some hard decisions about what to cut in order to fund developments.
- There will also be increased professional concerns about potential job losses.
- Increasing ‘commodification’ risks that we sacrifice *relationships* for ‘transactions’.
- The introduction of ‘peer specialists’ will be easy to do badly.
- We need to consider how to embed Recovery into professional training.
- How can we interest the research community in Recovery?

However, ........
“The greatest danger for most of us is not in setting our aim too high and falling short, but in setting our aim too low and achieving our mark.”

Michelangelo (1475-1564)
Thank you

For further information, contact:

Jed.Boardman@centreformentalhealth.org.uk
or
Geoff.Shepherd@centreformentalhealth.org.uk