POSITION PAPER

SAINSBURY CENTRE for MENTAL HEALTH
removing barriers achieving change

Implementing Recovery

A new framework for organisational change

Introduction

Making Recovery a Reality (Shepherd *et al.*, 2008) provided a summary of the key principles of recovery and their implications for mental health care practitioners. We argued that there are three main principles underlying the recovery philosophy: hope, agency ('control') and opportunity. And we began to explore how mental health services could best support the recovery journeys of those using them.

At the heart of recovery "...is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life" (Shepherd *et al.*, 2008).

Making Recovery a Reality formed the basis for a series of workshops on implementing recovery in organisations which were held in five mental health trusts in 2008/09. The workshops were attended by more than 300 people including a range of health and social care professionals, managers and representatives from local independent organisations, plus extensive input from service users and carers. Their aim was to identify the ways in which recovery principles could best be incorporated into routine practice in mental health services. The project was supported by an expert steering group which included some of the best known leaders in the field. More information about the steering group and our recent work on recovery can be found on the Sainsbury Centre web site at www.scmh.org.uk.

The workshops identified some of the key changes that will be needed in the practices of mental health workers, the types of services provided and the culture of organisations.

This position paper summarises the key organisational challenges that were identified in the workshops. More detailed discussions of the challenges for mental health services, and those who commission them, will be published later in 2009.

Ten key organisational challenges

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

Implementing Recovery: Ten key organisational challenges

1 Changing the nature of day-to-day interactions and the quality of experience

If recovery is really going to be the defining feature of our mental health services, there needs to be a fundamental change in the quality of day-to-day interactions. Every interaction, by every member of staff, should reflect recovery principles and promote recovery values. They should increase personal control ('agency'), acknowledge non-professional expertise, reduce power differentials, increase opportunities for a life 'beyond mental illness' and validate hope. These are illustrated in the 10 Top Tips for Recovery-Oriented Practice (see Shepherd *et al.*, 2008).

Mental health organisations also need to look at the internal 'pathways' they create for people moving through the service, such as their referral systems, assessment and care coordination, and discharge policies, and ask if these support or obstruct recovery processes.

2 Delivering comprehensive, service user-led education and training programmes

To achieve consistent change in staff attitudes and behaviour we need to introduce comprehensive, service user-led education and training programmes for all staff, across all professions and at all levels. This requires a supply of trained service users to act as the 'champions of change'.

3 Establishing a 'Recovery Education Centre' to drive the programmes forward

We suggest that a 'Recovery Education Centre' is established in every NHS mental health trust in England, staffed and run by service user-educators and linked to the delivery of the trust's recovery strategy. Each centre would train and support people with lived experience of mental health problems to tell their stories and to promote awareness of recovery principles among staff and other service users. It would also begin to train people as 'peer professionals' to provide direct care within the service (see below). It would need to work with local education providers to ensure that the training is of a consistently high standard and begin to offer accredited courses. A beneficial offshoot of this development would be the general promotion of an 'educational', rather than a 'therapeutic', model within the services, which would place an emphasis on learning from one another and assist in promoting self-determination and self-management.

4 Ensuring organisational commitment, creating the 'culture'

But training is not enough. Recovery values need to become embedded in every management process in the organisation – in recruitment, supervision, appraisal, audit, planning and operational policies. These values also need to be reflected in the publicly stated principles and values of the organisation, e.g. in mission statements, 'straplines', language and publications. This is what we mean by creating a recovery 'culture' within the organisation. It will demand leadership from the top (Board level) as well as commitment from the middle levels of management and practitioners at the 'front line'.

Managers will also need to use relevant information about performance and progress, such as local audit projects and national surveys, to feed back to the organisation on progress towards achieving key, recovery-oriented goals.

5 Increasing 'personalisation' and choice

The recovery culture should be reflected in the organisation's key operational policies and procedures. For example, it should lead to increased personalisation and choice and increased agency and control. This follows from providing more information and encouraging self-management; more joint planning for crisis management (building on 'advance directives'); more shared decision making regarding medication; greater choice over treatments and, where possible, over clinicians; and greater use of advocacy and individual budgets.

6 Changing the way we approach risk assessment and management

One of the key operational areas for reform is risk assessment and management. We must accept risk as an intrinsic part of living with mental health

problems. “The possibility of risk is an inevitable consequence of empowered people taking decisions about their own lives” (Department of Health, 2007).

The challenge is to evaluate risk assessment and management arrangements according to recovery principles. We need to ask, “Did this risk procedure increase or decrease the person’s sense of control? Did it increase or decrease their access to opportunities outside mental health services? Did it increase or decrease their hope for the future?” Risk assessment and management therefore need to become more open, more transparent, with service users and staff working collaboratively together. This is particularly important in forensic and other ‘high risk’ settings, where recovery is just as important a principle as it is in any other part of the mental health service.

7 Redefining service user involvement

We also need to redefine service user involvement. It is not a case of one group ‘involving’ another. Both groups must work together in as equal a partnership as possible. To talk of how to involve service users is immediately to distance service users from the centre of the care process and to reinforce traditional ‘them’ and ‘us’ distinctions. In reality, service users are already involved. The more important question is, “How can we all work more effectively together as partners, helping people to build their lives in the ways that they wish to?”

8 Transforming the workforce

Eventually, we believe that this will lead to a fundamental review of skill-mix and professional/service user ‘balance’ within the workforce of mental health organisations. As services become more truly focused on service users’ needs and accept the value of ‘lived experience’, so there are obvious implications for the composition of the workforce. Professionals will remain important, but they will have to recognise that their contribution needs to be made in a different way, acknowledging service users’ self-defined priorities.

By contrast, we expect to see a greatly expanded role for ‘peer professionals’ in the mental health service workforce of the future. We recommend that organisations should consider a radical transformation of the workforce, aiming for perhaps 50% of care delivery by appropriately trained and supported ‘peer professionals’ (using the proposed local Recovery Education Centre to train and support these new staff).

This has obvious organisational implications for Human Resource departments and Occupational Health services, but it is supported by the requirements of the Disability Discrimination Act and is consistent with the demands of the Government’s national Public Service Agreement target, PSA 16, to increase the proportion of people with mental health problems in paid employment (in this case within mental health services). These new workers will, of course, require the same kind of management support and supervision as any other professional group. This should come from peer professionals who have had the opportunity to accumulate greater experience and confidence in these roles. It will therefore take time to build up.

9 Supporting staff in their recovery journey

All these changes have profound implications for staff. Mental health workers are people too and as part of the organisational change process we will have to ensure that we support them (and carers) in their recovery journeys, making it ‘safe’ for them to prioritise the needs of service users and to raise their expectations and hopes. Staff will remain the key ‘carriers of hope’ and we need to create a culture which values their ‘lived experience’ of mental health problems and frees them to respond to service users’ priorities, rather than bureaucratic or professional agendas.

10 Increasing opportunities for building a life ‘beyond illness’

Finally, implementing recovery means opening up the organisation, turning it around to be outward-looking and not inward-facing. It needs to develop its partnerships with non-mental health agencies, particularly housing and employment, so that these become the central focus, not secondary add-ons. Service users need to be helped to use these opportunities to build the lives they want for themselves. Services need to focus on inclusion in the community, not just on ‘integration’ (which can often mean simply occupying the same physical space as others). We believe that access to paid

employment opportunities is particularly important in this respect.

The problems of stigma and discrimination will also have to be addressed. They remain major barriers to people with mental health problems being able to build meaningful and satisfying lives. Mental health services therefore need to continue to help whole communities to change their attitudes towards including people with mental health problems as full citizens, (for example through targeted anti-stigma campaigns, including those directed at health services – see Thornicroft, 2006). Communities need to own the concept of recovery. Like mental health and wellbeing, recovery is "everybody's business" (Future Vision Coalition, 2009).

Conclusions

We still believe that the greatest challenge for recovery ideas is translating fine rhetoric into tangible changes 'on the ground'. We hope that articulating the challenges for organisations will help providers and commissioners to get to grips with the problems and produce practical improvements.

This framework can be developed into a self-assessment instrument which will assist provider organisations to evaluate their own recovery journeys. Alternatively, it can help to create a common language for commissioners and providers to work together to 'co-produce' system change and agree local outcome targets ('objective' and 'subjective'). We believe that this will need to be a local process, since each mental health service is starting from a different point and the priorities will need to be locally agreed. We are currently working to develop both approaches.

Of course, any process of organisational change will not be simple or linear – it will be complex, multi-faceted, dynamic and interactive. Each local service will need to choose where to begin and what goals to set. We hope that the key organisational challenges identified in this paper provide a framework for making these choices.

References

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Future Vision Coalition (2009) *A Future Vision for Mental Health*. London: NHS Confederation.

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