Developing a Recovery orientation: Mental Health Services and Professionals

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Implementing Recovery through Organisational Change (ImROC)

A 3 year project (2009 – 2012) funded mainly by the Department of Health and delivered by a partnership between the Centre for Mental Health and the MH Network of the NHS Confederation
Recovery: how do organisations need to change?

- **Practice** – staff and professional training
- **Service Organisation and Delivery**
- **Culture of Services**
- These 3 areas should be addressed in parallel
- Practices and services should be based on best available evidence – combined with person-centred values (Evidence-based and Values-based)
Implementing Recovery through Organisational Change (ImROC)

Began as The (Sainsbury) Centre for Mental Health project ‘Supporting Recovery’

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.

4. …… and formulated a list of the ‘10 key Organisational Challenges’ to moving towards more Recovery-oriented services

5. 2010 - Obtained a grant from Department of Health to run at ImROC project in NHS Mental Health Services in England
Implementing Recovery through Organisational Change (ImROC)
Formulated a list of ‘10 key Organisational Challenges’

Developed a methodology based on closed audit loops, P-D-S-A cycles (joint goal-setting, implementation, review, repeat). Recommended by Iles & Sutherland (2001) as most effective.

29 Sites:
- Demonstration sites’ (n=6) already well advanced
- ‘Pilot sites’ (n=6) some progress, but keen to do more
- ‘Network sites’ (n=17) just beginning
Changing services, changing lives

- Worked with 29 sites in England (NHS + independent sector + users/carers)
- Delivered more than 50 joint training sessions, ‘co-produced’ between staff and service users, to more than 400 staff, service users and managers
- Supported recruitment, training and support of more than 150 Peer Support Workers in a variety of roles, working alongside staff and as peer trainers
- Established 6 Recovery Colleges, offering more than 300 courses. 4 more Colleges due to open by the end of the year. International collaborations in Italy and Holland (Japan).
- 7 Trusts have undertaken major revisions of their systems for risk assessment and management, one (Dorset) is specifically trying to eliminate seclusion and restraint (‘No Force First’).
And, more on:
Carers, Peer Support,
Risk Assessment & Management,
Quality and Outcomes ...

https://imroc.org/about-us/
National profile

Rt. Hon. Norman Lamb, Minister of State for Care and Support
14th February 2013

“Implementing Recovery through Organisational Change’ (is) a bit of a mouthful, but as a project it is absolutely outstanding. It is exactly the kind of thing we mean when we talk about focusing on outcomes, because it’s a scheme that, when everything is said and done, gets real results. …… …… Across all the sites, this project has meant three things for the people who use services. It has meant more choice, so services are designed around individuals and not staff. It has meant more of a focus on self-management, which is a far more sustainable way of approaching mental health. And it has spread the concept of the expert patient far wider than it has gone before, making the clinician/patient relationship more equal, which is how it should be”.
Recovery-orientated services – changes required

10 Key challenges
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. 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’ (e.g. IPS)
Pro-recovery interventions

- Advance Directives
- Wellness Recovery Action Plans
- Illness management and Recovery
- REFOCUS
- Strengths model
- Supported Employment Individual Placement and Support
- Supported Housing
- Mental Health Trialogues
- Peer Support Workers
- Recovery Colleges/Recovery Education Programmes

A model for cost-effective, MH services to support recovery

- Peer Support Workers (50%?)
- Treatments (medical and psychological for both mental and physical health)
- Inpatient wards (‘No Force First’, Joint Crisis planning)
- Specialist teams (EI, crisis teams)
- Social integration, local anti-stigma
- Inpatient wards
- Money (PHBs, welfare advice)
- Housing
- Employment (IPS)
- Recovery College(s)
Recovery Practice Framework – International best practice

- Seeing beyond ‘service user’
- Meaningful occupation
- Service user rights
- Social inclusion

Promoting citizenship

Supporting personally defined recovery

Recovery-oriented practice

Organisational commitment

Working relationship

- Individuality
- Informed choice
- Peer support
- Holistic approach
- Strengths focus

- Recovery vision
- Workplace support structures
- Workforce planning
- Care pathway
- Quality improvement

Partnerships
Inspiring hope

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

2. Coproduced Recovery focused learning and development opportunities are available for all staff working in services

3. Coproduced, Recovery focused learning opportunities are available for everyone using the service where people with mental health conditions, the staff and families who support them and others in local communities can share expertise and learn together

4. Recovery focused leadership at every level and a culture of Recovery

5. Increasing personalization and choice

6. Reducing restrictive practice; changing conceptions of risk as something to be avoided towards working together to improve safety

7. User involvement is replaced by fully resourced coproduction so that the views, experiences and aspirations of people using services and their family members are accorded the same value as the views of staff in the organisation

8. Transforming the workforce

9. Supporting staff in their recovery journey

10. Prioritisation of life goals (full citizenship and community integration) in all care planning processes
Recovery-Oriented Practice

A thematic analysis of 30 international documents describing recovery based practice and services found it depended on:

- Support for personally defined recovery
- A change in working relationships
- Organisational commitment
- Promoting citizenship

...a shift of professional orientation

**From:** centring on illness and diagnosis  
**To:** relationships with people, choice and preference  
- __________

**From:** focus on treatment and interventions  
**To:** education and enabling people to discover what works best for them  
- __________

**From:** authorities and experts who are ‘on top’  
**To:** mentors, guides, peers and coaches who are ‘on tap’  
- __________

**From:** an narrow focus on Clinical Recovery and symptomatic improvement  
**To:** a broad focus on Personal Recovery and gaining a satisfactory life as evaluated by people themselves
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
Training for recovery oriented practice
A provisional curriculum

Understanding for all practitioners

1. Understanding the origins and guiding principles of recovery
2. Personal reflections on recovery – what have you learned from your own experience?
3. Reflections on personal recovery – what can we learn from recovery narratives?
4. Personal approaches to distress - culturally appropriate and trauma informed care
5. The importance of language that enables and supports recovery
6. Concerns and challenges to ‘recovery approaches’

Skills for all practitioners

- Creating a hospitable and welcoming environment
- Supporting self management
- Building on strengths and working to personal goals
- Enabling self direction and control: personalisation and personal budgets
- Working with peer support
- Developing recovery education for personal recovery
- Bringing it all together: recovery-oriented care planning
- Developing natural supports and promoting community participation


Medical responsibilities: specific issues

Understanding
1. Engaging with knowledge and skills for all recovery oriented practitioners

Additional understanding
2. Recovery and realism: open to all?

Additional skills
3. Promoting recovery for people detained under the Mental Health Act
4. Reconsidering risk and safety
5. Medication management and supported decision making
6. Tracking progress – evaluation and outcome measures
7. Continuing professional development: supports and resources
8. Practitioners in context: participating in organisational change
9. Practitioners in context: participating in societal and cultural change

After each interaction, ask yourself did I...

- actively listen to help the person make sense of their mental health problems?
- help the person identify and prioritise their personal goals for recovery
- demonstrate a belief in the person’s existing strengths and resources?
- identify examples from my own ‘lived experience’ which inspires and validates their hopes?
- pay particular attention to the importance of goals which enable the person actively to contribute to the lives of others?
- identify non-mental health resources relevant to the achievement of their goals?
- encourage self-management?
- discuss what the person wants in terms of therapeutic interventions, respecting their wishes wherever possible?
- behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership, indicating a willingness to ‘go the extra mile’?
- while accepting that the future is uncertain continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations?
Person Centred Care

• “We suggest these can all be related to a broad overarching (or underpinning) ethical idea that patients should be “treated as persons.” (Entwistle and Watt, 2013)

• central principle of ‘personhood’, described by Bill Anthony as simply “people with severe mental illness are people” (Anthony, 2004).

• Each offers useful pointers to key issues and good practice


Person-centred Care

- “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions”


The Health Foundation (2013):
- employ a ‘partnership’ approach with people focusing on the following four elements:
  - Affording people dignity, compassion and respect.
  - Offering coordinated care, support or treatment.
  - Offering personalised care, support or treatment.
  - Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.


“...a process that is people focused, promotes independence and autonomy, provides choice and control and is based on a collaborative team philosophy. It takes into account people’s needs and views and builds relationships with family members. It recognises that care should be holistic and so includes a spiritual, pastoral and religious dimension. The delivery of person centred care requires both safe and effective care and should result in a good experience for people. This responds to the need expressed by NHS Wales to be able to describe the key determinants of a “good” experience to help both users and providers in assessing how people feel and achieve improved outcomes as a result of the care and services they receive”

Welsh Government, 2015, Health and Care Standards Wales page 8
Person-centred care may be seen as an umbrella term encompassing a range of different but related factors

- Shared decision making.
- Self-management support.
- Co-production.
- Personal Recovery.
- Values-based practice.
- Human rights.
- Ethics and Philosophy.
- Social Inclusion.
- Compassion, Empathy, Kindness.
- Spirituality.
- Reflective Practice.
- Patient Narratives.
- Formulation Skills.
RCPsych - Person Centered Training and Curriculum Scoping Group (PCTC)

Some recommendations

• Create a curriculum that is ‘person-centred’
• To include in the curriculum competencies related to Person Centred Care, including shared decision making, self-directed support, co-production, collaborative care and support planning
• To include in the curriculum competencies related to broader aspects of Person Centred Care (ethics, human rights, social inclusion etc).
• Strengthen the role of users of services in planning and delivering MRCPsych courses and supplementary skills training
• Include users of services in planning and delivering MRCPsych courses and supplementary skills training
• Create guidelines and standards for course organisers for working with users of services in the teaching for the MRCPsych courses.
• Promote the involvement of trainees in Recovery Education Colleges or related opportunities in their local areas
RCPsych Core Values for Psychiatrists 2017
Recovery is for All
Hope, Agency & Opportunity

• Benefits to clinicians
• Benefits to service users
• Covers all mental health specialisms
• Placing greater value on personal knowledge of the individual
• Greater emphasis on personal priorities of service user
• Balanced and evidence-based approach to treatment
• Readdress the historically subordinate interests of people with mental illness
You need to keep trying!

Come on! It can’t go wrong every time...
“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

Dr Jed Boardman