

***Recovery Focused Conference Bournemouth U./Dorset NHS
Engagement in Life: Promoting Wellbeing and Mental Health***

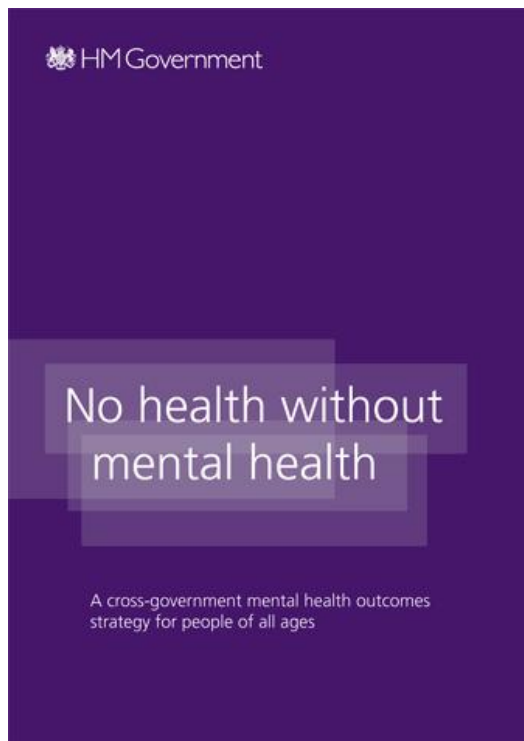
**Implementing Recovery through
Organisational Change – the ImROC
experience**

Professor Geoff Shepherd
ImROC Lead

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 and health policy (DoH/HMG, 2011)



Contains 6 objectives:

Objective ii. – 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”

N.B. Defines ‘Personal Recovery’ not ‘Clinical’ Recovery

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The Project Team (part-time)

- Geoff Shepherd (Clinical psychologist, NHS manager)
- Julie Repper (Nurse, NHS manager)
- Rachel Perkins (Clinical Psychologist, Quality manager)
- Jed Boardman (Consultant Psychiatrist)
- Glenn Roberts (Consultant Psychiatrist)
- Miles Rinaldi (Vocational manager)
- +
- Dawn Fleming (Project manager)
- Alex Rushton (Comms. lead)

The ImROC programme: 2 key questions

Q1 - How to change the attitudes and behaviour of staff and teams so as to make them more supportive of recovery for people using services?

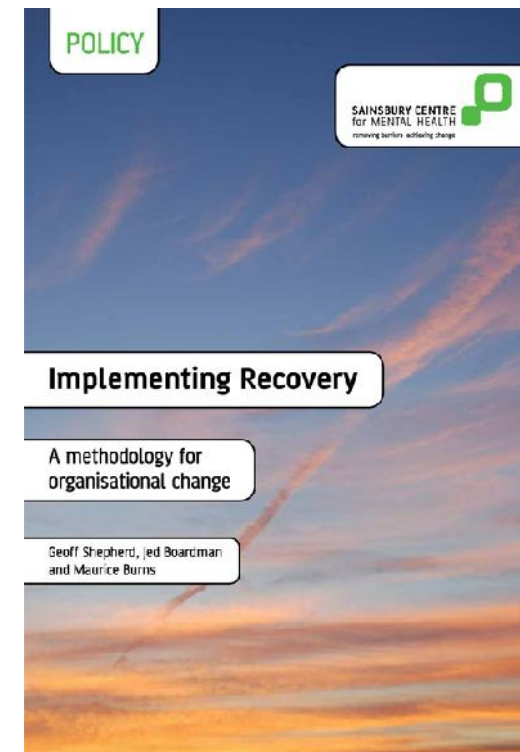
Q2 - How to change organisations such that these changes in staff behaviour are supported and maintained? (changing the ‘culture’)

The key organisational challenges

In 2008 identified 5 NHS Trusts and their local partners who had already made significant progress towards implementing more 'recovery-oriented' services

Ran a series of local workshops, involving more than 300 staff, service users, family members and managers.

Formulated a list of '**10 key Organisational Challenges**'



The '10 key organisational challenges' (SCMH, 2009)

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, 'co-produced' learning 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. Transforming the workforce
7. Changing the way we approach risk assessment and management
8. Redefining user '*involvement*' to create genuine '*partnerships*'
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life 'beyond illness'(e.g. IPS)


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What has ImROC achieved?

Changing services, changing lives

- ❖ Worked with more than 30 sites in England (including local NHS provider + independent sector + users/carers)
- ❖ Facilitated more than 50 'co-produced' training sessions on principles of recovery to more than 400 staff, service users and managers
- ❖ Ran 4 'Learning Sets' each attended by mixed groups from 6-8 sites to learn about specific topics and share experiences, problems and successes regarding service developments.
- ❖ Supported recruitment, training and support of more than 100 Peer Support Workers in a variety of roles, working as peer trainers and in staff teams
- ❖ Established 9 Recovery Colleges, more due to open by the end of the year. International collaborations in Italy, Denmark and Japan.
- ❖ Supported 7 Trusts in major reviews of their systems for risk assessment and management, trying to minimise use of seclusion and restraint

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Mental Health Network
NHS CONFEDERATION 

briefing

June 2012 Issue 244

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 for system change.
- 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.
- More evidence is required regarding the cost-effectiveness of key interventions to supporting recovery and the routine monitoring of recovery-orientated outcomes.

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 and its partners operates so that they 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 2010. 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 the opportunity to build a life 'beyond illness'.^{1,2}

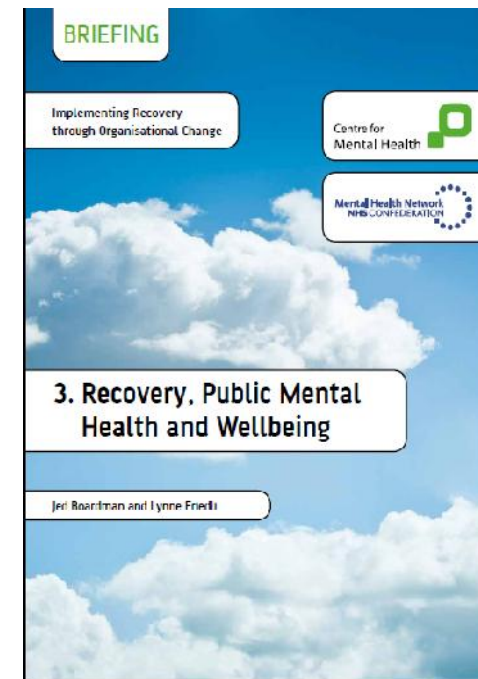
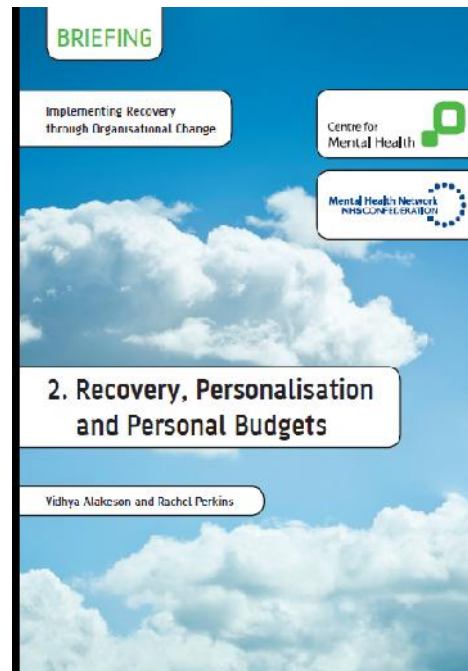
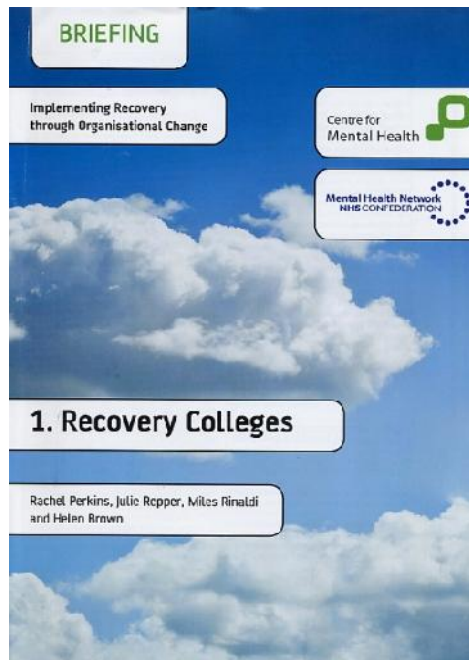
These principles are now central to national mental health policies in England and several other countries including the United States, Canada, Australia and New Zealand.³

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".

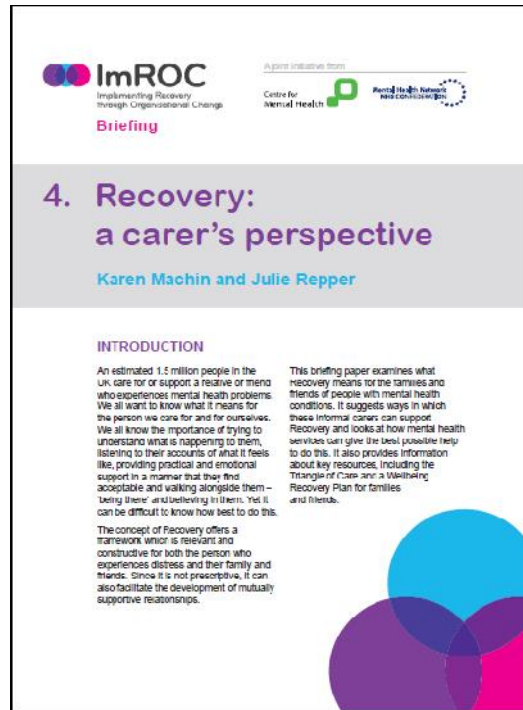
The document says: "More people who develop mental health problems will have a good quality of life – greater ability to manage their own lives, stronger social

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Briefing papers (www.ImROC.org)



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4. Recovery: a carer's perspective

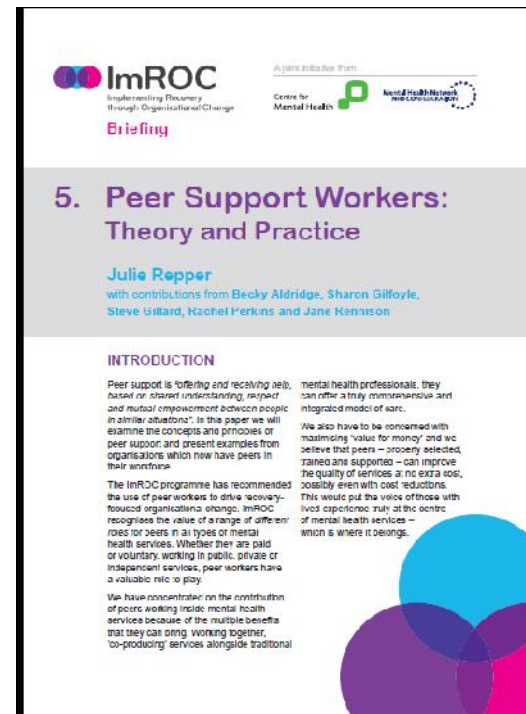
Karen Machin and Julie Repper

INTRODUCTION


An estimated 1.5 million people in the UK care for or support a relative or friend who experiences mental health problems. We all want to know what it means for the person we care for and for ourselves. We all know the importance of trying to understand what is happening to them, listening to their accounts of what it feels like, providing practical and emotional support in a manner that they find acceptable and walking alongside them – 'being there' – at whatever they need. Yet it can be difficult to know how best to do this.

The concept of Recovery offers a framework which is relevant and constructive for both the person who experiences distress and their family and friends. Since it is not prescriptive, it can also facilitate the development of mutually supportive relationships.

This briefing paper examines what recovery means for the families and friends of people with mental health conditions. It suggests ways in which these informal carers can support Recovery and looks at how mental health services can give the best possible help to do this. It also provides information about key resources, including the Triangle of Care and a Wellbeing Recovery Plan for families and friends.



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Briefing

5. Peer Support Workers: Theory and Practice

Julie Repper
with contributions from Becky Aldridge, Sharon Gilfoyle,
Steve Gillard, Rachel Perkins and Jane Remison

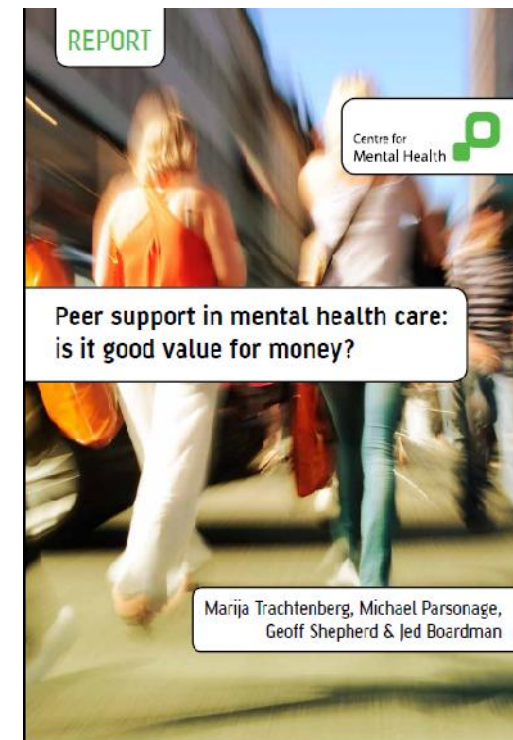
INTRODUCTION

Peer support is 'offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations'. In this paper we will examine the concepts and practices of peer support and present examples from organisations which now have peers in their workforce.


The ImROC programme has recommended the use of peerworkers to drive recovery-focused organisational change. ImROC recognises the value of a range of different roles for peers in all types of mental health services. Whether they are paid or voluntary, working in public, private or independent services, peer workers have a valuable role to play.

We have concentrated on the contribution of peers working inside mental health services because of the multiple benefits that they can bring: working together, co-producing services alongside traditional mental health professionals, they can offer a truly compassionate and integrated model of care.

We also have to be concerned with maximising 'value for money' and we believe that peers – properly selected, trained and supported – can improve the quality of services at no extra cost, possibly even with cost reductions. This would put the voices of those with lived experience truly at the centre of mental health services – which is where it belongs.



REPORT

Centre for
Mental Health 

Peer support in mental health care: is it good value for money?

Marija Trachtenberg, Michael Parsonage,
Geoff Shepherd & Jed Boardman

And, more on the way on:
**Team Recovery Implementation
Plans (TRIP); Peer Support II. Practical Implementation;
Risk & Safety; Quality and Outcomes ...**

What have we learned about changing organisations?

You must fail to succeed!



Everywhere is different

- National and local policies must acknowledge the unique history and characteristics of individual sites.
- This means having flexible methods that can enable services set locally relevant goals.
- It also means accepting that sometimes progress is slow.

Training is not enough

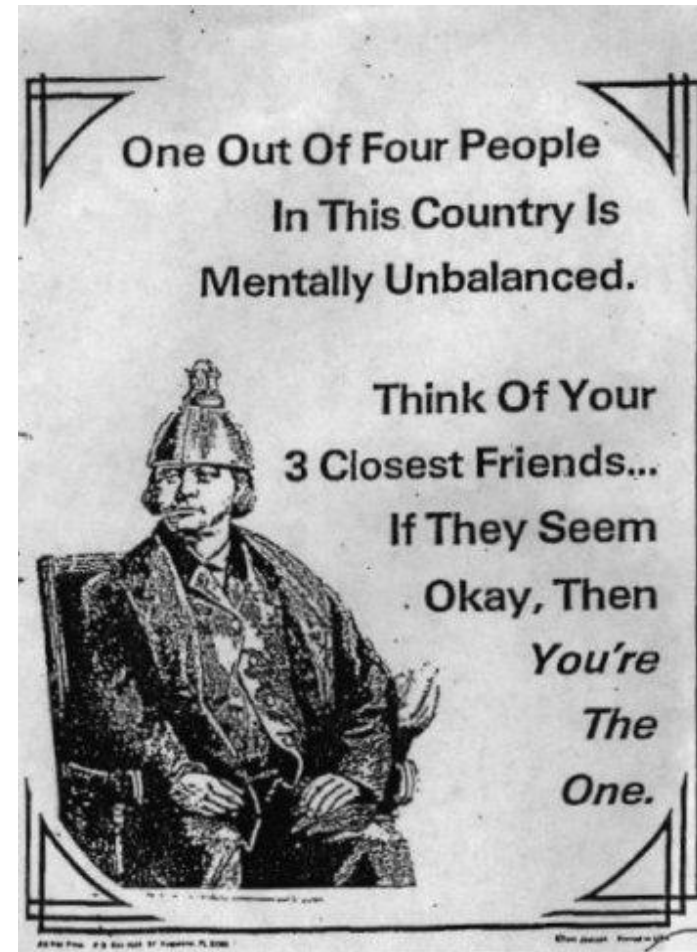
- ❑ Whitely *et al.* (2009) studied implementation of Mueser's 'Illness Management and Recovery' (IMR) programmes' across 12 community settings.
- ❖ Training was important, but only effective if issues of *supervision* and *leadership* were also addressed.
- ❖ Need for a '*culture of innovation*' in the organisation, i.e. organisations need to be ready to accept and embrace change.
- ❖ If all these factors were present, then they acted synergistically; however, if any were absent, then change was impeded

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Change is possible - 'co-production' is the key

- ❑ Recovery requires a different relationship between the people who use services and the people who provide them
- ❑ They have to recognise what they have in common, rather than what divides them
- ❑ This means not just 'involving' service users, but *'learning together'*
- ❑ 'Meetings between experts' – staff as a resource (coach, mentor) bringing life experience as well as professional training
- ❑ This will produce a service which is more tailored to individual needs and one which *feels* to be of a better quality

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Leadership is critical, but it is always dispersed

- Look for leaders at all levels.
- Existing staff are part of the solution, not part of the problem.
- Change requires effective project management at an operational level, supported by an appropriate strategy at an organisational level.



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Learning Sets are powerful vehicles for joint learning

- Sites organised into 'Learning Sets', with mixed stages of development
- Each site able to send up to 8 people to the workshop, with a mixture of professionals, third sector, service users (and carers)
- Each workshop consisted of formal presentations by experts on specific topics, followed by users' comments and discussions in which members share their experiences and learn from one another ('market stalls').
- Very successful in promoting shared problem solving, encouraging reciprocal contacts and inter-site visits between sessions, creating a 'learning network' (cf. cancer network).

The power of co-production



- The most powerful driver for change within NHS workforce is the inclusion of appropriately trained and supported service users and carers in staff positions
- Two specific service developments are particularly important: (a) Recovery Colleges and (b) Peer Support Workers
- These kinds of roles are powerful because they improve outcomes for those accessing the services; they benefit those providing the support; **and** they benefit the organisations in which they work

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The need for more research

- The progressive development of services will be significantly enhanced by a careful approach to the evaluation of individual outcomes
- We need to agree a consensus regarding an appropriate set of individual outcome indicators – and share this with commissioners
- These outcome indicators need to cover personal, psychological and social benefits to the individuals and also the effects in terms of possible reduced use of certain services (cost effectiveness)
- Local services then to develop and implement systems for routine monitoring. This will require both technical expertise and some additional capacity

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And a final message from our sponsors



**Dorset
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En

 promoting wellbeing & recovery
of Health

The Dorset Wellbeing and Recovery Partnership (WaRP)

“The greater 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)

Dorset HealthCare
University NHS Foundation Trust



Thank you

For further information contact

geoff.shepherd@centreformentalhealth.org.uk

www.imroc.org