

Spring Newsletter

Working in partnership with communities to develop systems, services & cultures that support Recovery & wellbeing

Welcome

Welcome to the first ImROC newsletter!

We will produce regular newsletters so that we can share stories of work we have been doing, ideas we are developing, publications we are producing and events that we are both hosting and attending. ImROC is an ever-expanding network of activity, with less opportunities than we would like to meet and share our experiences. We hope that newsletters are one way we can exchange information and learning – and we hope that people working for and with ImROC will contribute brief articles to make the newsletter real, relevant and up to the minute. This newsletter contains descriptions of some of the work we have been doing over the past year, so I



want to take the opportunity to share some of our plans for the forthcoming year.

In considering our future direction, the overwhelming contextual factor is the unprecedented financial pressures facing the services that we support. Policy is driving service transformation and integration as a means of increasing efficiency without funding for double running to

establish best practice and without the stability required to undertake rigorous evaluations. Consequently many of the sustainability and transformation plans (STPs) are based on tacit understanding rather than evidence of their potential to improve quality of services and outcomes of people using them. ImROC can, however, be absolutely clear that the support we offer is based on ever more convincing evidence that working towards recovery focused services can produce better outcomes at lower cost. For people using services, education and support to manage their own wellbeing, shared decision making in every aspect of their care (including crisis planning, individualised/ personalised social support, housing support, individual placement and employment support and practical and

In This Issue:



PAGE 3

Our Views



PAGE 8

Out In the Field



PAGE 14

emotional support from peer workers) have all been shown to achieve higher satisfaction with services, better outcomes and reduced use of costly inpatient and crisis services. For staff, working in recovery focused ways improves their job satisfaction, reduces sickness absence and reduces turnover of staff.

For the past 7 years, ImROC has been supporting health services to implement organisational changes which improve the recovery focused support of people who use those services. The ImROC approach is based on 'Ten Organisational challenges'; all of which require whole organisation commitment and leadership for success – with clear actions to be taken at macro/strategic, meso/managerial and micro/practice levels - and all of which are absolutely in line with current health and social care policy. In late Spring, we will be publishing our most substantial briefing paper to date, summarising the evidence underpinning each of the ten challenges in terms of outcomes, service user experience and economic evidence. Professor Slade (University of Nottingham) and Shepherd (ImROC), Sue Williams (CNWL and ImROC) and David McDaid (London School of Economics) will launch this Business Case for Recovery at an event targeting senior mental health service managers in Early Summer.

Other briefing papers that are

planned to respond to the challenges facing services include a focus on Workforce Wellbeing; the ImROC experience of Coproduction; and a flier that summarises the ImROC service improvement methodology. But ImROC has never been all about 'responding' to developments and we will be publishing two papers which lead the way in determining the relationship between Open Dialogue and Recovery, and describing Developments in ImROC Recovery Colleges.

Despite (or maybe because of) the financial challenges, ImROC continues to win contracts to support organisations and systems to build on their resources and strengths to support Recovery. Within the UK, the nature of this support is changing. We are increasingly running learning sets within organisations rather than for multiple organisations; we are shifting from whole organisation Recovery planning to targeted work on specific challenges; we are providing increased support to teams at the front line, coaching whole teams to offer more recovery focused support; and, we are building expertise in working across whole systems, coproducing new service pathways, developing community partnerships and supporting new ways of working such as social prescribing and peer navigators.

In addition, we are strengthening

our relationships with mental health services across Scandinavia, Western Europe and Asia - and as a result we are increasingly contracted to provide support in these areas. We frequently host international visits for organisations to see recovery-focused practice in action and we have built long term relationships with service providers in Sweden, Denmark, Japan, Hong Kong, Australia and Ireland, as a result more work in these areas is already planned for the coming year.

Finally, we will be shifting from a few large conferences towards offering a greater number of smaller, more targeted, interactive workshops and seminars where we will collectively drive forward cutting edge thinking and practice. We have already started this approach with peer support, running 'critical debates' to explore some of the tensions and conflicts surrounding the emerging role of peer support workers.

I look forward to future newsletters to chart our activities and developments. Please feel free to comment and contribute your ideas and opinions.

Julie Repper

Our Views

Recovery – which is to be master?

Written by Professor Geoff Shepherd

“When I use a word,’ Humpty Dumpty said in rather a scornful tone, ‘it means just what I choose it to mean — neither more nor less. But the question is,” said Alice, “whether you can make words mean so many different things. The question is,” said Humpty Dumpty, “which is to be master— that’s all.” (Alice through the Looking Glass)

We have seen that ‘recovery’ is a word with many meanings. Those of us who wish to encourage mental health services to make a better job of supporting recovery therefore need to be clear about which meanings we wish to promote. This is not easy. There are a number of misinterpretations of recovery which go entirely against its fundamental principles. However, before we reject the word entirely we should be careful about



Perhaps the most important idea to emerge from my own experience of trying to re-shape services to support recovery is the changing nature of power.

throwing out what are probably the best set of ideas for reforming mental health services in a generation. They provide a challenge to the power and position of traditional, mental health professionals and service priorities. Of course, there is a balance to be struck here, but it seems to me that the balance is invariably struck in favour of the professionals’ agenda, rather than the clearly expressed wishes of the people who use services, their friends, families and other carers.

Perhaps the most important idea to emerge from my own experience of trying to re-shape services to support recovery is the changing nature of power. ‘Co-production’ puts the people who use services and the people who provide them – at least in a formal sense – on the same ‘side’. By sharing power they increase it and can then achieve more than either could do on their own. As Foucault noted, they are both also transformed by this process. Power is not a ‘thing’: it is a relationship and supporting recovery, whether at an individual or an organisational level, is about changing this relationship. That is a challenge that we all find difficult. It is certainly something that is worth trying to keep alive.

Recovery and employment

Written by Professor Geoff Shepherd

Finally, to the specific question of employment. It is worth remembering that people with mental health problems still have the lowest employment rate of any disabled group and, according to National Patient survey data, only 43% report receiving any support in finding or keeping work and just under half of those not receiving help would have liked it. Thus, while it is certainly true that not everyone with mental health difficulties wants paid employment, many do and not simply for financial reasons (although the

benefits of extra income for people who are close to poverty are not to be underestimated). However, meaningful work also has psychological and social benefits and these are sometimes just as important as money. ‘I definitely want to work in something that I feel I’m contributing’ “I feel like I have a lot of untapped potential, if I can stay well I can make something of my life”....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. That makes me feel good”

Thus, as Rachel Perkins has said many times, it is surely as bad to condemn someone with mental health problems to a life of boredom, worklessness and social isolation, as it is to force them back into employment in positions which they don’t want and find stressful or demeaning. At the very least we should be aiming to offer specialist, effective help for all those who wish to return to work as a matter of routine practice. This would mean making developments like ‘Individual Placement and Support (IPS) available as a standard element in local mental health services not, as they currently are, a very rare commodity

Our Views

Coffee anyone?

Written by "B" (Peer Support Worker)

It has been five years since I completed and graduated from my peer training course with the Institute of Mental Health. The training had been a journey of highs and lows, tears and laughter, challenges and in many ways, an adventure of discovery too. I would say it was one of the most challenging training courses I had ever attended but I would not change it for the world. It helped change my life in so many ways for ever.

With my wellness plan in hand, I had everything going for me. I knew what to do to stay well and was determined this would be the beginning of my journey of maintaining employment....something I had not managed to do to date, due to my own mental health distress.

After applying for a role as a peer support worker I attended an interview, taking with me a piece of drift wood. That piece of drift wood was one of nature's treasures, a very dear friend had found it for me while on holiday. It didn't matter from which angle you looked at it, animal shapes and forms seemed to spring out of it. It represented taking delight in the small things in life, looking for people's treasures as they walk their journey of life. Im not sure if it was that piece of wood that got me the job or the fact that I had found my dream job and wasn't going to let this opportunity pass me by without a fight. Either way I somehow managed to persuade the interview panel that they needed me on their team...thus gaining a post working on the acute wards at a local adult mental health hospital.

In all my years of employment I had never managed to hold down a job for more than a few months. I was so scared I would fail again, especially because I believed this was the job I had been searching for all my life. I could see that all the years of torment and depression, distress and self hate had been for a reason. I finally had some worth and could give back and belong to society. Something I had never felt before. All those negatives turned into something very positive and my journey of recovery had taken a leap forward.

I had been working for a few months/years as a peer

support worker when my mental health took a nose dive. All the things I usually did to keep myself well such as listening to music, seeing people who were important to me and knitting were no longer working. Sadly I had to take some time out, to evaluate what was happening and what I was doing in my life. It was time to really put into practice all the skills I had learned on my peer training course for myself.... practice what I preached so to speak.

While off work, I became aware that I was very quickly spiralling into not being able to get out the house. If I was to ever get back to work I realised I needed to do something now before it was too late. I had to find a solution to this challenge.

That's when I decided to challenge myself and start pushing my boundaries back out. I decided to go to a coffee shop with some knitting and sit quietly in a corner. I wasn't sure I could do it but I had to try. A well known coffee shop had recently opened a new store, it was large enough to be able to sit away in the corner quietly, without being disturbed.

The first time I went, I sat with a small drink, not knowing how I would even stay there, but I managed to drink the coffee and knit for about 20 minutes. That felt like such a huge step for me back then. A few days later I went to that same store again with my knitting, not speaking to anyone other than to order my drink. This continued for a number of days, each day I would manage to stay a little bit longer too.

Before long I found myself looking forward to going out the house, knowing I had a treat of rewarding myself with a coffee and to sit quietly knitting in a safe corner. Those 20 minutes soon turned into an hour or sometimes two. I was going daily by now, The store managers were getting to know me as were some of the other regular customers. I very quickly gained the nickname of 'the lady who knits in the corner'. Regular customers would say hello to me and ask what I was knitting. I was making new friends and beginning to have conversations with people. The staff at the coffee shop all knew me by now and I was getting to know them. If for some reason I missed going for a coffee one morning they would ask where I had been and if I was ok.

Our Views

My social network had increased. I had made friends with people, both staff and customers. I always took my knitting because I found it helped me stay relaxed. I had to smile when a customer asked if I took knitting orders. Soon other people would come in asking for me, because they had something they wanted me to knit for them.

I was feeling well again, that simple act of taking myself off to a coffee shop, sitting quietly in the corner, not talking to anyone and knitting had begun a whole new chapter in my life. I was getting out and about, and coping with daily life again. I had overcome my challenges and regained control of my depression. I was able to relax and be around people again, I looked forward to each day and enjoyed chatting to people. Quite often I found myself using my peer skills to encourage others who were struggling, that's when I recognised I was well and recovering again....

With support from occupational health, human resources and a couple of NHS employees in particular I went back to work in a new role in the community that summer. To this day I have continued to go back to that same coffee shop on the mornings when I am not at work, because it is one of the things that continues to help me stay well. I still see and chat to the other

regular customers and frequently get asked to knit things. I made some good friends who have become part of my support network and I continue to make new friends as customers and staff come and go. One store manager is in particular is now a good friend, whom I now babysit for, that's because I chose to knit a little jacket for his newborn son as a thank you gift for his support and acceptance of me.

The coffee store also supported me last year when I had my head shaved for Macmillan Cancer...by offering to host the event. I am so grateful to the coffee shop and staff there. It took all the courage I could muster to walk through this doors initially but from that small step came more rewards than I could have imagined back then. My life is richer, more amazingly I have continued to sustain employment for years instead of just a few months. My journey of recovery continues, with each challenge I face, more healing and freedom becomes available. I realise now more than ever before that my recovery is completely in my control...I just have to be brave enough to take those steps along the road to recovery and discovery.

To finish, I am still known as 'the lady who sits in the corner knitting' or "B" to the regulars. Sometimes now though to challenge myself, I don't sit in the corner.

Recovery ignores the socio-political context

Written by Professor Geoff Shepherd

As for recovery ignoring the individual's social, political and cultural context, this is a travesty. Supporting individual recovery is, at its heart, essentially a social process (see Mary O'Hagan and many others). And, since most peoples' personal recovery goals revolve around having somewhere decent to live, something meaningful to do, feeling a part of your community and having supportive, personal relationships, then it must have primarily social, not therapeutic, goals. Even the Department of

Health defines recovery in social terms, "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" (Objective ii. in 'No Health without Mental Health', 2011).

It is therefore just plainly wrong to suggest that supporting recovery locates all the problems within the person and is 'apolitical' in that sense. The reverse is true.

Supporting recovery is about explicitly trying to ensure that people with long-term mental health difficulties have access to the same range of social opportunities for good housing, good employment and social support that everyone else has by encouraging 'hope', 'control' and 'opportunity' in their lives (Repper & Perkins, 2003). It is clear that people with mental health problems are often specifically disadvantaged in this struggle and we have argued repeatedly it is therefore important to ensure that services give these areas their first priority.

Our Views

Recovery as a justification for service reductions

Written by Professor Geoff Shepherd

The next idea that figures largely in the anti-recovery discourse is the notion that promoting recovery is simply a device for justifying the reduction of services. Listening to some politicians and commissioners over the past few years this sounds quite plausible. It is certainly the case that mental health services have suffered savage reductions in the last few years, but that has not been done in the name of recovery. It was done initially to address the profligacy and corruption of international bankers. More recently, this rationale has been dropped and government has made it clear that it is simply part of a longer term policy to reduce

public expenditure (and by implication to increase expenditure on private providers).

In ImROC we have always made it clear that service reductions must be a consequence of people recovering their preferred lives: they cannot cause it. Otherwise, one could get everyone to 'recover' by simply closing all services! That might appeal to those who are most keen to reduce public expenditure, but it is not appealing to the rest of us. My own suspicion is that those who criticise supporting recovery as opening the way for service reductions are actually expressing their broader – and very correct - concerns about the policies of austerity and their effects on public services. But it is important not to get the two mixed up. It is like blaming shortages of school or hospital places on EU immigration.

Recovery as part of an attempt by professionals and managers to control people

Written by Professor Geoff Shepherd

Perhaps foremost among the 'other fish' that haunt the pool of recovery is the notion that supporting recovery is part of an agenda orchestrated by managers and professionals to take over control of peoples' lives. If this is the case, then it would clearly be fundamentally in opposition to recovery values. However, I have to ask, exactly who it is that wants to use supporting recovery in this way? I have seen the proposition stated a lot, but I have never seen it attributed. I assume that those who are thought to be behind it are either doing it unconsciously, or are being very clever in not making it explicit. I have to say that I'm too old to believe

carefully orchestrated subliminal campaigns and it therefore looks to me like a carefully constructed 'straw man' for which there is really very little evidence.

In fact, the World Health Organisation, which is not exactly known as the voice of radical management ideas, appears to support a version of recovery which is based on a careful understanding of the person's needs for support as defined by them and puts peer support in a central place.

.... "From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self. Recovery is not synonymous with cure.... The core service

requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise".

Surely, this is a version of recovery which most of us could sign up to – including most managers and professionals? At the heart of it is 'co-production' and at the heart of co-production is the sharing of power.

Our Views

'Recovery' means 'cure'?

Written by Professor Geoff Shepherd

The notion that supporting recovery implies that the person must first be 'cured' has plagued the movement right from the beginning. But it is surprising that it has hung around for so long. In 1993 Bill Antony made it very clear that, 'The concept of recovery from physical illness and disability does not mean that the suffering has disappeared, all the symptoms removed, and/or the functioning completely restored' (Antony, 1993). Similarly, Mike Slade built his book around the distinction between 'clinical' recovery and 'personal' recovery (Slade, 2009). In ImROC we have repeatedly stressed the importance of this difference, but the confusion persists. Maybe anything that has anything to do with 'health' has to have a 'cure'? I have to say that anyone who still thinks that supporting recovery is impossible without complete symptom relief is either fearfully ignorant, or has other fish to fry. What might these be?

'Recovery' as a semantic problem - is it all just in a word?

Written by Professor Geoff Shepherd

It must be acknowledged at the outset that there is a semantic problem with the word 'recovery'. It has a well-established common meaning, viz. (the process of) 'returning to a normal state of health, mind or strength' and this is how it has been used in the context of mental health. However, it also has a number of associated meanings based on underlying

implications which may - or may not – be shared and made explicit. This can lead to a passionate debate simply based on different understandings of the word and a failure to clarify terms. This conversation sometimes seems pretty hopeless and not going anywhere. Unless we can agree what we mean by 'recovery', maybe we should simply abandon the word altogether and seek some new semantics?

We would not be alone in this conclusion. For example, I was struck recently re-reading the experience of Mary O'Hagan in New Zealand who says, "I was one of a small team of service users who wrote the recovery content in the Mental Health Commission's Blueprint for Mental Health Services in New Zealand. We debated at length about whether to use the term 'recovery' or not. If we had been able to agree on another word we would have jumped for it. It was thus partly by default that recovery found its way into our policy and discourse".

That is exactly how many of us thought at the beginning of ImROC. Mary O'Hagan's solution was to suggest a new definition of recovery as 'the individual and social processes that ensure people with ongoing or episodic mental health problems can live well'. This is much better - and simpler – and accords with an even shorter definition given to us by a service user at one of our Learning Sets, 'Recovery is about helping people live the lives they want to lead'. This is admirably concise and makes it very clear where the control must lie in the support of personal recovery. ImROC would be very happy if this version of recovery were to become widely adopted, but before this is likely to happen, a number of other issues need to be addressed. These are what I will examine next.

Recovery: 'the great debate'

Written by Professor Geoff Shepherd

The word 'recovery' is highly contested. For some people, it is seen as just another attempt by professionals and managers to take control over service users' lives. They believe it requires that everyone with mental health problems must be 'cured'; it locates all the problems within the individual; it strips people of their unique social, political and cultural context; and is part of a (not so) hidden government and professional agenda to reduce services and force

people back into employment.

On the other hand, there are those of us – and this includes ImROC - who believe that the framework of recovery ideas provides fundamental challenge to the way that mental health practitioners practice and the way that mental health services are organised. It puts service users and carers where they belong, at the centre of service priorities and, through the promotion of 'co-production' between those that use services and the professionals who largely run them, it attempts to ensure that service developments are planned and

delivered by professionals and service users (and carers) working together.

This ensures that they are more relevant and more effective – especially if effectiveness is judged primarily by those whose are on the receiving end.

These two perspectives seem so far apart that it is almost impossible to believe that they both started from the same point. How did we get into this muddle? This series of blogs attempts to explore these different ideas and suggest some much-needed clarification and working definitions that, perhaps, we can all agree on.

Out In The Field - UK

Working with Oxford Recovery College

Written by Toni King

Oxfordshire Mental Health Partnership formally brings together six local mental health organisations from the NHS and the charity sector with Restore acting as the lead partner in delivering the Recovery College. Oxford Recovery College were early in their development and with a change in staffing felt they would benefit from ImROC support. A 5 day bespoke package was developed drawing on consultants with different expertise to best meet the needs. Using the recovery principles all would expect, we identified and explored assets and

expectations; co-production; sustaining & growing ORC and team resilience. The high energy days included a range of exercises to develop common ground, action plans and experience in using tools which can be adapted and reused as staff and ORC continue to develop. The experience and passion of the team meant we moved between process and practical issues, hopes and fears, poignant moments and laughter, evidence base and experiential expertise. By the end of our work, Oxford Recovery College had established close working links with a 'sister' service who attended aspects of the Consultancy days. Through sharing experience and reflecting on differences and parallels in their recovery college journey a clear

reciprocal and mutually beneficial alliance was established. Ambitions to engage stakeholders and engage senior managers were in hand and plans for Quality Assurance and evaluations were drafted ready for sign off. The ability of ImROC to provide consultants with both strategic and operational expertise was valuable in meeting the needs of a project early in its development and ambitious in its aspirations. The willingness of the team allowed the sessions to evolve to meet the agreed content and individual needs – this flexibility and genuine upholding of recovery principles were identified as invaluable talents for the future of ORC.

Northern Ireland

Commencing with an initial meeting with colleagues back in June 2012, Dr Rachel Perkins & Jane Rennison led an 18 month project (June 2013 – December 2015) which involved working with the 5 Health and Social Care Trusts across Northern Ireland.

They were invited back to facilitate a one day workshop, with 50 colleagues from the South Eastern Trust in October 2016 to review progress to date, to consider sustainability and the future shape of services; and to support the Recovery Steering Group find a renewed energy and clear focus for their future work.

The day was an opportunity to reflect and celebrate progress with regards to the development of their Recovery College, introduction of PSWs into the workforce, increasing personalisation and choice; and implementation of outcomes and evaluation. The ImROC consultants brought a helpful objectivity, facilitating discussion regarding the

challenges and barriers and possible solutions. They also shared information regarding further national and international developments since working with the Trust in December 2015 with some suggestion on what the Trust might need to consider next in order to learn from the experience of others travelling a similar journey but further down the path; and brought their attention to a range of outcome measures since developed which they might consider using.

Participants were supported to consider how the work to date would be sustained; and how recovery focused practice would shape the services over the coming 3 – 5 years.

The progress has been phenomenal and is testimony to both the strength of partnership between the Trust, their commissioners and the ImROC Consultants; and the recovery focused leadership evident within the Trust.

Written by Jane Rennison

Out In The Field - UK

ImROC/NSFT

Written by Professor Geoff Shepherd,
Senior Consultant



Following a critical report by CQC in 2015 on mental health services provided by Norfolk and Suffolk Foundation Trust (NSFT) a 'buddying' arrangement was set up between the Trust and Nottinghamshire Healthcare FT. This included money to be spent on improving various aspects of the mental health services. As part of this, Nottinghamshire Healthcare recruited specialist help from ImROC to review existing services and assist them in moving towards more explicit support for recovery. This process has been overseen by Julie Repper.

ImROC Senior Consultant Geoff Shepherd was asked to contribute to this programme. Geoff had previous contact with NSFT including supervision of post-doctoral research by one of the senior clinical psychologists in the Trust (Dr. Corinna Hackman, Research Development Lead for Adult Services/NIHR CLAHRC Fellow) who was completing a realistic review of the effectiveness of peer support and an exploration of the mechanisms underlying peer support using attachment theory.

It was agreed that Geoff would facilitate two half-day sessions: one on the application of recovery principles in the development of the Wellbeing service (expanded IAPT); and one on identifying priorities and approaches to implementation for their new Recovery Strategy. These sessions took place on 28th November 2016.

Both were well attended, the first mainly by practitioners and managers from the Wellbeing Service, the second by senior managers from the Trust. Feedback was very positive.

"Thank you for a very helpful and inspiring day with lots of outputs to help complete the details of the strategy. Your presentation and style has helped to reinforce my own determination for embedding recovery principles at NSFT. In my view, the troubles the Trust has had over recent years provides an opportunity for us to go further, deeper and more quickly into ImROC than would otherwise have been the case in this rural region in which the prevailing culture tends towards the more traditional clinical model than is often the case in more urban based Trusts. I will look forward to sharing with you a copy of the finalized strategy document which we hope to have printed before the end of the year".
(Marcus Hayward, Head of Recovery, Participation & Partnership, Hellesdon Hospital, NSFT)."

I also felt the sessions went well, particularly a role play in which staff and service users played out an initial interview where the interviewer (staff or service user) was given only basic information about the person they were interviewing. It was then interesting to see what additional information different interviewers elicited, e.g. staff elicited information consistent with a professional orientation, whereas service users produced a much broader picture of the person's situation.

The afternoon session with the managers on the Recovery Strategy went well, but it remains to be seen how much it is followed through given all the other pressures the Trust is now under.

Out In The Field - UK

Family, Friends and Carers in Northumberland, Tyne and Wear

Written by Sara Meddings

This year has seen the first ImROC Family, Friends and Carers learning set. It has been held in Northumberland Tyne and Wear with bespoke topics to meet the needs of the Trust. The Trust is already well established both in terms of its work with the Triangle of Care, common sense confidentiality and in training staff to deliver NICE guided Family Family Interventions and family therapy.

The learning sets have been facilitated by Sara Meddings partnering with the Meriden family programme for the first day and introducing Simon Betts (peer specialist trained in family interventions) for the second and third days.

- Working together to manage risk and safety: People who use services, relatives and carers and staff
- Improving the Experience of Discharge from mental health services – how the process can be more recovery focused for people who use services and family, friends and carers
- A third day is being planned around identifying and supporting young carers.



The days have been well attended with 50-60 people at each, from a range of mental health and learning disability services, including staff, people who use services and relatives and carers. The days have been well attended with 50-60 people at each, from a range of mental health and learning disability services, including staff, people who use services and relatives and carers.

Each of the days has concluded with either the development of local action plans to take forward the work or with the development of good practice principles. Feedback has been positive with attendees saying they would recommend an ImROC Family Friends and Carers learning set to others. They have especially appreciated the focus on families and carers and being able to listen to the perspectives of each group in the triangle of care so that they can work together to improve local services.

Other Trusts might be in different places in their development of services which are more inclusive of family friends and carers – for example they might choose to focus on introducing the triangle of care, family inclusive practice, common sense confidentiality or developing carer peer roles.

Out In The Field - UK

Recovery College Learning Network

Written by Waldo Roeg

ImROC has been hosting The Recovery College Learning Network over the last two years facilitated by Waldo Roeg, Jane McGregor and Sara Meddings. It is a membership network of Recovery Colleges, a combination of NHS Trusts, educational and Third Sector Organisations, that come together to support each other and learn what has worked and try to join up the excellence that exists across Recovery Colleges nationwide. It has also been a vehicle in trying to underscore and create the fidelity that makes up an ImROC recognised Recovery College whilst embracing the differences that individual sites have.

It has enabled ImROC to help support Recovery Colleges that are just starting up to link in and learn from Colleges that are further along their journey.

We have had three learning days since April this year where we have looked at the 'Student Journey', 'Outcomes and how to measure them' and 'How we Reach out to Everyone' making it as accessible as possible. Two further days are planned this year on 'How to obtain commercial buy in' and 'Staff engagement'. In response to members' suggestions, we have shifted from centrally hosted days to each member hosting network days facilitated by ImROC. Having space and time to look at what has worked and what has not through Action Learning Sets, sites are able to formulate action plans that can then be reviewed at the next learning day.

We have also used digital technology to help support the member sites through Webinars and access to the ImROC website, where members are able to upload and download useful information and resources that they may find useful.

We are currently reviewing how we can support recovery colleges in 2017/8 and beyond. This may include in-house learning sets, external peer reviews of recovery colleges, on-going mentorship and networking opportunities.



Out In The Field - UK

Coaching work in Nottingham

Written by Sue Barton

There was some confusion within a small team in the Trust about roles and responsibilities which had led to a break down in relationships. A request was made to use recovery principals to consider how the team could work more effectively together moving forward. Two sessions were run with a small group of staff where we explored the different roles of team members; how to handle issues when the responsibility is grey; how to make the meetings more productive and specific behaviours/ways of working which help or hinder.

The group worked hard both within and between the sessions.

Specifically they:

- Adopted a set of ground rules as a basis for all their work together and which could be used as a mechanism for enabling constructive challenge if a

member of the team has concerns.

- Discussed and agreed the different roles of team members.
- Established a way of working in partnership between managers and clinicians that they agreed to model in the future.
- Reviewed and improved the meetings structure and delivery
- Agreed some one-off actions that they all felt would help.

At the end of the second session the group were asked to give a word or phrase to sum up their feedback, the words used were:

- Improvement in progress
- Hopeful
- Exciting
- Reassuring
- Positive

News

Australasian Recovery Colleges get together to share and learn

There are a small number of well-established recovery colleges in Australia and many more on the way in both Australia and New Zealand. Seeing the increasing diversity and interest in this approach, the Mind Recovery College™ team decided to invite all interested people working in or developing new colleges to come together in October last year to build relationships and share ideas. Over the two day meeting there was unanimous support for the establishment of an Australasian Recovery College Community of Practice which is now in existence. If you want to know more about what was discussed feel free to email dianne.hardy@mindaustralia.org.au for a copy of the notes from October

Out In The Field - International

Working in the Republic of Ireland

Written by Dr. Julie Repper

Work in Ireland preceded the existence of ImROC with both Professor Geoff Shepherd and myself visiting Mayo Rehabilitation Service to give papers on Recovery. We were both impressed by the commitment and energy of Dr Dominic Fannon, a consultant psychiatrist with a real passion for recovery, determined to find resources to develop local services. It was, therefore, not surprising when Dominic asked whether Mayo could join the first round of ImROC learning sets in 2011. What was remarkable was the speed with which this team began to implement the learning! Within two years they had a Recovery College, peer support workers and had bid, in partnership with ImROC for funding to replicate the ImROC approach in the Republic of Ireland. This was successful; funding was received from Genio and ARI (Advancing Recovery in Ireland) was born.

ARI began, much like ImROC, by selecting 7 HSE (Health Service Executive) mental health services to join a Recovery learning set for one year, and then planned to expand this offer to the remaining 11 sites two years later. A small central team was set up to support the sites between learning sets and ImROC provided support the central team as well as attending and speaking at all the learning sets. These first 7 sites have developed Recovery committees, agreed Recovery priorities, developed new services, trained staff and raised the contribution of people who use services, and it is this success, together with HSE recognition of the potential of Recovery to solve many of the challenges they faced, that led to the integration of ARI into the HSE after two years.

Positioning Recovery inside the National HSE Office brought the advantages of: ensuring accountability, increasing visibility and affording opportunities for Recovery to be integrated in national work programmes. ImROC continued to support learning sets and offer advice and support but progress slowed down due to delays in determining what the HSE commitment meant in practice, questions from the HSE about the role and purpose of ARI, the requirement to see the outcomes of ARI with outcome research being commissioned. Alongside these questions for ARI, the structures and organisational units of mental health services across Ireland have changed several times in this time, rather than the 17 Areas involved in initial discussions, there are now 11 Community Health Organisations meaning that new management teams are being constituted and services across each patch are only beginning to develop relationships and understanding.

Nonetheless, ARI, led by Michael Ryan (who was using services in Mayo when this journey began), with support from ImROC, has advised, inspired and facilitated services across Ireland to focus on Recovery. The achievements that ARI lists include:

The development of local groups ('Recovery Committees') in advancing Recovery practices. These groups are made up of service users, family members and service providers (HSE staff) working together. Some of the great work that these groups are involved in includes:

- 'Recovery Principles Training' coproduced training led by family member, service user and professionals and delivered to the same three groups of stakeholders.
- Developing 'Recovery Colleges' in four different CHOs - with more planned.
- Opening 'Peer-led involvement centres' to provide peer support for people with mental health conditions.
- Bidding for funding to employ peer support workers.
- Developing innovative services such as Open Dialogue.
- Setting up 'Consumer Panels' where service users meet up together to share their views on the local mental health service and feeding this back to the service.
- 'Recovery story-telling'. Peers supporting people in hospital by sharing stories of their own recovery.
- 'Dialogues'. Holding community talks about mental health where everyone's voice gets heard and we tackle together the stigma of mental distress.

ImROC continues to support ARI, and is now working with Genio, the funding body responsible for implementation of the Service Reform Fund. This has been established to support the implementation of person-centred services and supports, in line with HSE policies such as Transforming Lives and A Vision for Change. It has set four priorities for people with mental health problems including: implementation of the Individual Placement and Support (IPS) to increase employment among people with mental health conditions; improve mental health support services for people who are homeless; and shifting the culture of services so that they are more Recovery focused with an emphasis on coproduction, prevention and self-management. ImROC is currently supporting the development of a national Recovery framework to support these service improvements, and working with services to build engagement with communities and increase capacity to facilitate Recovery.

Upcoming Events

PEER WORKER CRITICAL DEBATE – WHAT IS THE ROLE OF PEER SUPPORT?

1 JUNE @ 10:00 AM - 3:30 PM

Date: 1st June 2017

Time: 10:00 – 15:30

Venue: Nottinghamshire Healthcare NHS Foundation Trust

In June 2016 we met in Nottingham to explore and debate critical issues around a peer workforce. It was a fascinating, busy day and we covered a wide range of issues: should peer workers be trainer in the management of violence and aggression, how to achieve a critical mass of peer workers within a service, what a peer worker career pathway looks like and many other topics. One core issue we returned to in our discussions was what is the role of peer support? There were differing views from peer workers needing clearly defined roles and duties to those who felt peer working was an approach to every activity and interaction.

The debate

On 1st June 2017, we will focus solely on What is the role of peer support? We are grateful to be joined by Jane Rennison and Sue Williams from Central and North West London NHS Foundation Trust who will argue 'it's not what we do it's the way that we do it' and Steve Gillard from St George's University of London setting out

why peer workers should be distinct roles. We will hear both sides of the debate and the audience will vote. Time will also be dedicated to hear about recent development in peer support and an exciting peer initiative from Dear Albert Drug Rehabilitation service. Julie Repper will join us to facilitate table activities and discussions on what this means for us locally.

Delegate rates:

£100 plus VAT for ImROC sites,
£150 plus VAT for non ImROC sites.

To book your place(s) please click here <https://www.surveymonkey.co.uk/r/7V52GLR>

REFOCUS ON RECOVERY 2017

18 SEPTEMBER @ 9:00 AM - 20 SEPTEMBER @ 5:00 PM

To find out more information on this event and to make a booking visit <http://www.researchintorecovery.com/ror2017>. **Please note, booking for this event is not made through ImROC.**

Refocus on Recovery 2017 is the largest regular scientific conference on recovery in the world, and will take place on 18-20 September 2017. The conference is all about recovery for people with mental health problems, and is presenting world-leading research about

how people can live well with illness. It is being organised by the Institute of Mental Health, School of Health Sciences (University of Nottingham), Nottinghamshire Healthcare NHS Foundation Trust, ImROC, Making Waves and Mental Health Foundation. Four themes have been agreed for the conference:

IMROC HOSTED VISIT FOR REFOCUS ON RECOVERY 2017

21 SEPTEMBER

We are delighted to be working in partnership with Refocus on Recovery 2017 to support their conference and provide an ImROC Demonstration Day on 21 September 2017 to showcase the work of Nottinghamshire Healthcare NHS Foundation Trust. At this full day conference we will share the breadth of Recovery-focused practice including the supporting and enhancing the peer workforce, developing and expanding a recovery college model across the Trust, valuing and benefitting from lived experience, and developing a recovery strategy. Places will be limited, to register your interest please email imroc@nottshc.nhs.uk