19. Creating a Recovery Focused Culture: changing the nature of conversations from the bottom up

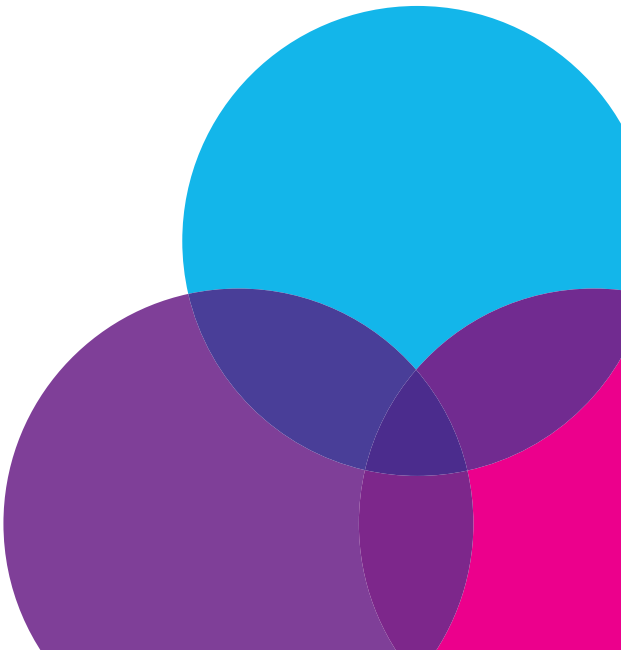
Rachel Perkins, Julie Repper and Kirsty Giles

INTRODUCTION

If services are to become more recovery focused then recovery principles and values must permeate every facet of organisations (Shepherd et al 2009). Creating recovery focused services is not about adding a new intervention or service to our repertoire but about fundamental cultural change. This centrally involves a transformation in the individual interactions - between staff and people using services and those close to them, and between staff colleagues - and the attitudes and values that underpin them.

"Culture can be defined as the whole character and experience of organisational life … existing in and reproduced through the social interaction of participants" (Scott et al, 2003, p111)

Efforts to change the culture within services have typically taken a 'top down' approach. Many services develop a kind of 'initiative fatigue' in trying to implement the numerous national programmes that emerge from 'on high' ('the productive ward', 'releasing time to care', 'the first 15 steps', multiple service redesigns ….). When staff are subjected to a plethora of 'top-down' directives they often feel alienated, disempowered and unable to use their own initiative. It is too easy for the development of recovery focused practice to be seen as yet another top-down directive.



Empowering people who use services must mean empowering relationships at the front line: recognising the centrality of such relationships in changing culture and recognising the power of front-line staff to make a very real and important difference.

The focus of many of these 'top-down' initiatives is 'learning from mistakes' and putting right that which has 'gone wrong'. Many of the policies and procedures in services have emerged from inquiries into 'critical incidents' and 'near misses' and are designed to stop such things happening again. While this may be important, on the ground the effect is often to create defensive practice in which the main aim of staff is to avoid making mistakes. If we are to create recovery focused services then we must focus and build on the strengths, achievements and possibilities of everyone using and working in them. How different would our policies and procedures look if they had been based at least as much on learning from what had gone well rather than solely learning from mistakes?

Too often, in trying to develop 'recovery focused' practice we make lists of things that staff do that is not 'recovery focused'. If staff are to face this challenge of developing more recovery-oriented practice they must believe that they can do a good job, that their strengths are recognised and that their positive efforts are acknowledged and valued. Too often staff perceive that a 'blame culture' predominates. Achievements go unremarked and it is only things that go wrong which attract attention and censure. This focus is on 'learning from mistakes' with scant attention to learning from success can leave staff feeling punished for what they do wrong but rarely praised for what they do right. This can lead to a kind of 'learned helplessness' (" what's the point of trying, I'll never get it right" see Seligman, 1972). A sense of control and self-determination are diminished and too often people report feeling unable to pursue the values and ideals that brought them into this work in the first place. The sense of passivity so often reported by people who use services is reflected in the staff who provide them. The fear of 'getting it wrong' stifles the 'culture of innovation' that is so important in the development of recovery focused services (Whitely et al, 2009).

The challenge in creating recovery-oriented services is to enable all staff to recognise their role in transforming culture and practice. Even in a climate of 'top down' rules, front line staff have the power to change individual conversations. It is often the little things, not the grand initiatives, that make the biggest difference to the experience and development of both people who use services and the staff providing them.

In creating change, it is easy to rely on staff training as 'the answer'. Training is important in the development of recovery-oriented services, but this needs to go beyond basic 'introduction to the principles of recovery' to encompass, for example, coaching approaches, personal recovery planning, recovery focused approaches to risk and safety, self-management approaches, shared decision making …. Such training is not just about teaching a set of skills via traditional 'chalk and talk' methods. It must instead explore and build on participants' ideas, skills and experience within a framework of recovery values. It must value and build on the expertise gained from both research and lived experience of front line staff from different backgrounds/professions, people living with mental health challenges, those who are close to them, people managing/ developing services and the expertise available within communities and community organisations. If all of these groups learn together then opportunities for shared exploration and learning that can lead to mutual understanding are enhanced.

However, education/training alone is not enough. Whitely et al (2009) found four factors worked together to facilitate a recovery focused service culture: recovery focused education, organisational commitment, recovery focused leadership and a culture of innovation. There has been considerable attention paid to the organisational commitment and leadership required in the '10 key organisational challenges' adopted by ImROC (Shepherd et al, 2010). It is probably true to say that the primary focus in many services has been on larger service changes (such as introducing peer workers, developing recovery colleges and establishing different approaches to risk and safety). The first key organisational challenge - changing the nature

of day to day interactions – remains the most elusive, alongside creating a culture of innovation and the front line leadership that is required to achieve this.

The purpose of this briefing paper is to explore ways in which recovery focused transformation of services can be reflected in, and driven by, changing the nature of conversations at the front line and empowering teams to create their own solutions.

WHAT SORT OF CONVERSATIONS? FROM THE 'PATIENT IN OUR SERVICES' TO THE 'PERSON IN THEIR LIFE'

If we are to change the nature of our conversations, we must first ask, what is the purpose of our service and the conversations within it.

Traditionally it has been assumed that the purpose of services is to reduce and eliminate problems, deficits and dysfunctions. In this context we have focused on 'the patient in our services' and their needs in terms of what we have to offer (inpatient care, a day service, psychological therapy etc.). Our primary goal has been diagnosis, treatment and symptom reduction so our conversations have focused on the nature and aetiology of their difficulties. We have then used our expertise to prescribe solutions for them. Their personal history, strengths, goals, social circumstances, activities, values, beliefs etc. have been considered only in so far as they inform decisions about diagnosis, treatment, support and prognosis.

The purpose of a recovery focused service is to help people to rebuild their lives.

As surgeon, Professor Atul Gawande, said in his 2014 Reith Lectures 'The Future of Medicine':

> *"We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being - and well-being is ultimately about sustaining the reasons one wishes to be alive… Medicine must shift from a focus on health and survival to a focus on wellbeing - on protecting, insofar as possible, people's abilities to pursue their highest priorities in life."*

In order to do this we must understand what drives the person, the nature of their 'highest life priorities'. This means that, in thinking about recovery we need to start in a different place, not with the 'patient in our services' but the 'person in their life and community' – where they have been, what has happened to them, who and what is important to them, what they have got going for them and what they value – the 'reasons they wish to be alive'. Symptoms, diagnosis, prognosis, treatment, support and services must all be considered not just in terms of how much they reduce problems but how far they enable the person to do the things they want to do and live a satisfying, meaningful and valued life as part of their community.

We cannot understand the person in their life and community through a 'one size fits all' checklist. If we are to begin to understand the person, and if they are to feel heard, they need a chance to tell their own story in their own words. Simple questions like 'What has happened?' (rather than 'what is wrong?)', enable people to tell their story; taking time to listen, believing their account, exploring their experiences … can be very powerful. Personal narratives form the basis of recovery. We can learn a great deal about the person, their culture and their life if we let them tell their story about what happened to bring them to services. There will be some information that we have to collect but much may be covered in the course of the person telling their story when we take the time to actively listen.

To know the person we need to understand their story. This may be achieved by exploring a number of areas but there can be no prescriptive check list. This is a conversation, or, more likely many conversations over a period of time. It is a dialogue in which we must share something of ourselves. The aim is to create a trusting, collaborative relationship - but trust is not a one way street. If we expect people to trust us with their confidences then we must share something of ourselves (see, for example, Safe Wards 'know each other[1], Dunlop et al, 2021; Perkins, 2021). The conversation is not simply a data collection exercise, it is an opportunity to consider the impact of different factors, potential explanations and solutions in an ongoing and reciprocal relationship.

Over time we may want to explore a number of areas:

- **What the person sees as their most pressing concerns/needs.** This may not be their mental health problems it could be money, housing, safety, children, relationships … it is important not to jump to conclusions and people's concerns usually change over time.
- **What the person has done to try to cope with problems they are facing.** Many people have tried lots of ways of dealing with difficulties, some of which may have been quite effective. Together we can build on these and avoid replicating things they have not found helpful. What help are they already receiving? Is there anything else that they think might help?
- **Their situation and the meaning for them of what has happened.** The way in which they understand what has happened and how it has affected their life, relationships and roles. The practicalities of their life including their living arrangements, employment/education, finances, general health, transport/getting around, relationships community, and how these may help or hinder their recovery.
- **Hope and fears.** Anything that the person is frightened of, anything that makes them feel unsafe (or frustrated, or angry, or hopeless …), anything that keeps them awake at night. What might alleviate their anxiety and help them to feel safe? Who might best provide this?
- **Their courage and strengths.** People often understandably focus on their shortcomings and perceived deficits, weaknesses, but amid these lie a great deal that is worthy of respect:
  - the **courage** it takes to recognise problems and seek help
  - the **courage and ingenuity** it has taken to keep going with such difficulties
  - the **creativity** in working out ways of keeping going

Whilst acknowledging the magnitude of the challenges they face, we must spend time discussing their own strengths and resources – and those available to them within their family, friends and communities. Solutions do not lie exclusively in services. Services can help identify, support and develop a person's resources rather than be the sole provider. Such discussions can help people to recognise that they have some agency:

- **Their personal resources:** coping strategies, sources of strengths, protective factors, experiences of coping with adversity, values and activities that are important to them, inner resources that the person draws on.
- **Things that make the person 'tick':** values and beliefs, things that are important to the person, give them a sense of purpose and a reason to get up in the morning.
- **Their diverse range of strengths:** skills and talents, personal virtues, educational qualifications, work and work experience, interpersonal skills and resources, overcoming adversity, spiritual/faith resources.
- **Their social resources:** family, friends, neighbours, colleagues, support networks, services, faith communities, other communities of which they are a part and the resources within these.

1 https://www.safewards.net/interventions/know-each-other

- **Their sources of security and hope:** people to whom the person turns when they need help or solace, sources of hope and strength, spirituality and philosophy.

We cannot help people in their journey of recovery by understanding their problems and resources alone. We cannot help someone to get somewhere in their life unless we know what is important to them and where they want to go. We need to understand and help the person to explore:

- **Short term goals:** not just 'getting rid of symptoms' - what would be different? What would you be able to do that you cannot do now?
- **A vision for the future:** hopes and dreams for the future - what do you want to do with your life? Have these changed? What did you want to do with your life before your problems started/when you were young? If you could wave a magic wand, what would be different/how would you know things were different?

We all know that the people who are close to us often understand a great deal about our strengths and resources, our hopes and dreams, and our most pressing concerns. Sometimes they can help us to articulate these when we are not able to do so ourselves. As mental health workers we always need to recognise that, while recovery may be a personal journey, it is not one travelled alone. It is one travelled in the context of friends, families and communities. Those who the person sees as important to them may have valuable information to impart and may be valuable allies in the person's journey.

LITTLE THINGS MAKE A BIG DIFFERENCE

Probably the most difficult aspect of working as a mental health practitioner is understanding how each little thing we say or do is received by the people we are there to support.

When the ward is very busy, the telephone is ringing and the doctor wants to go through the drug charts and someone comes to the office door wanting to speak to you for the third time that morning it is very easy to wave them away or tell them that you are too busy at the moment. It is all too easy to expect them to be able to see how things look from your perspective – being harassed on all sides. However, there is another perspective. The person may have lost all their friends, no-one from their family visits, they are not allowed off the ward because they are a suicide risk, and have only the staff with whom to share their loneliness and distress. You are the only person who is there for them, and you are too busy. The sense of yet another rejection is immense. There is no easy answer. You have the unenviable task of deciding which is most important: to speak to the person, answer the phone or talk to the doctor? Your instinct tells you that the person's needs are paramount, but the doctor tells you how busy they are and you have no idea how important the telephone call might be. Perhaps you can ask the doctor to wait for a moment while you speak to the person? Perhaps you can ask the doctor to answer the phone while you do so? Perhaps you can then apologise to the person for keeping them waiting … answer the telephone and tell the caller you will ring them back … It is difficult to think through the options and their implications in the split second you have to make the decision. But perhaps the essence of taking a recovery-oriented perspective is to change some of the traditional hierarchies.

How often do we, as a team, discuss such dilemmas together? Consider how to balance priorities. 'People before paperwork' may be a good maxim, but this does not make the paperwork go away. There have been numerous initiatives around 'protected time' for staff to spend with people, perhaps this is looking at things the wrong way round?

Perhaps we should be talking about 'protected time' for paperwork and assume that for the majority of our time we are available to people using the service? Would we wave away, or ignore the doctor when they want our time? Probably not, we may apologise and give an explanation, arrange another time to see them … treating the people that our service is there for with the same respect as we accord colleagues is the least we can offer, but we do need to discuss and agree this as a team?

Similar dilemmas arise in every part of the service. In a busy community team, how do we respond to the person who calls several times a day asking for help? Too often the traditional response is to 'set limits' ('your care worker will come and see you next week') in an attempt to discourage 'inappropriate attention seeking'. But how does this feel for the person who is calling you? They feel at the end of their tether, they have no-one to talk to. They really do value your help. They really do feel that they will have to take drastic action if they do not get help, even though you do not believe their situation to be critical. It is not easy. We cannot talk to a single person all the time, but from where the person sits they are continually being rejected, they feel no-one recognises how difficult things are for them. Any one of us knows how important it is that our friends and colleagues acknowledge our distress. How often do we call them to check they are OK? If we reached out on a regular basis – proactively recognising their distress rather than passively rebuffing or ignoring their approaches – then we demonstrate that we care, that we are interested, that we are there for them … if we arrange to call them regularly (daily if necessary) rather than waiting for them to call us then distress ceases to be the only way they can get the attention that we all crave. If we call them we can talk about their achievements as well. But again, this requires us to discuss and agree this approach as a team. It requires all of us to think through the person's situation, what our role is and the consequences of different courses of action. If we rebuff the person's approaches, all too often they do escalate their calls for help until we are unable to ignore them. What are our values? What are our attitudes to the person?

In both of these examples, **the challenge is to move beyond our perspective, appreciate how things look from the other person's shoes and recognise our common humanity.** Treat the person on the ward as we would treat the doctor and treat the person who calls us repeatedly as we would wish to be treated ourselves, or how we would treat our own family members.

This latter example also illustrates the importance of the language we use and the relationship between language and thought. If we label someone as 'attention seeking' this defines their behaviour as a 'problem' to be eliminated. If instead we label them as distressed or frightened these are emotions that all of us share. Every one of us needs acknowledgement, recognition, attention, someone with whom to share hard times as well as good times. Most of us have friends, family, colleagues to provide us with this. Too often the people who use services have no-one to turn to but services. Once we start to recognise our common humanity and label their behaviour differently our response changes.

The language we use to speak and write about people has a significant influence on the way in which we respond to them. Although many services aspire to a strengths based approach, the reality often falls short. A brief perusal of the records of anyone using services reveals that the number of words describing deficits, dysfunctions and problems far outweighs the space devoted to strengths, possibilities and personal aspirations. Given the pressure of work in mental health services it is hardly surprising that we develop short-hand language. Given the prevailing focus, this short hand invariably describes problems: 'non-compliant', 'difficult', 'attention-seeking', manipulative', 'lacking motivation'. This has two consequences.

First, it describes the person and their behaviour in negative terms. Someone who does not agree with what we think is best for them may be described as 'non-compliant', but they could equally be described as 'knowing their own mind'. Someone who tries to get us to do what they think is best may be labelled 'manipulative' while a member of staff who tries to get the person to do what they think is best is more likely to be described as a good clinician.

Second, it robs the behaviour of its context and meaning. It tells us little about the person's situation and how they see the world, both of which are critical if we are to help them. As the 'Independent investigation into the care and treatment of Daniel Gonzales' (2009) says *"The recovery ... philosophy requires the professional to be curious about what drives the service-user, what is meaningful to him, and why.."* If we say that the person is 'non-compliant' this tells us nothing about why the person's perspective differs from our own and what is important to them.

Although most services aspire to offering choice, the language we use frequently assumes that our way of looking at things is the correct one and that we have the answers about how to put things right.

Typically we use 'you' language: you have schizophrenia, you are suicidal, you are vulnerable. This implies that our construction of events is correct and too often leads to the polarised confrontations ('you have schizophrenia', 'no I haven't', 'yes you have' …) that mitigate against the formation of collaborative, recovery focused relationships. If we instead use 'I' language ('I think you might have schizophrenia', 'I am worried that you might hurt yourself/that about other people taking advantage of you') then we introduce the possibility of discussion of different perspectives ('I think this, what do you think?') that allow us to understand each other's perspective, even if we end up agreeing to disagree.

Often we tell people what to do to make progress ('my advice to you is …', 'You need to …' , 'You should …'). This assumes that we know what is best for the person. Just as there is no single correct construction of events, there is no single correct road to recovery. Each person must find their own way, work out what helps them and develop their own 'personal medicine':

> *"When describing their use of psychiatric pharmaceuticals or "pill medicine", research participants also described a variety of personal wellness strategies and activities that I have called "personal medicine". Personal medicines were non-pharmaceutical activities and strategies that served to decrease symptoms and increase personal wellness"*
> (Deegan, 2005, p.30)

If we are to assist people in doing this our role is not to tell people what to do but to help them explore different possibilities: from 'my advice to you is …' to 'some people have found X helpful, some people have found Y helpful, have you had any thoughts about what might help you?'.

As well as exploring the language we use, we also need to examine some of our accepted ways of doing things. Often we have 'one size fits all' rules ('no visitors in your room', 'you cannot have your mobile phone') which often reflect a kind of 'lowest common denominator' approach to safety: if one person is 'not safe in the kitchen' then no-one can use the kitchen unsupervised. Alternatively, such rules may be reinforced by ideas about fairness: it is difficult to ask Jane to get up at 8 am so she can go to a therapy group if Fred is allowed to stay in bed until 11am. Whether through ideas about safety or fairness, blanket rules prevent us tailoring services to individual needs and preferences. For example, the general rule may be 'no visitors between 12 noon and 2pm'. If a person's relatives have to drive a long way to reach the ward, maybe this is the only time they can visit. Keeping in touch with family and friends may be more important that sticking to blanket rules.

It is important not only to think about what we do but the way in which it is done. The rule 'no mobile telephones' can be delivered in different ways. The person could simply be told to hand over their phone because they are not allowed on the ward. It would be equally possible to apologise for not being able to let them have their telephone, explain why the rule exists, and how they can make a call if they want to. Common courtesy is at least as important to people using services as it is to the staff who work in them!

It is also worth thinking about the messages that our services convey about how we value those whom we serve. How do we welcome people? What do our initial appointment letters say? What messages do our 'zero tolerance of violence' posters, or our separate 'staff' and 'patient' toilets, convey? How does it feel to have to speak to the receptionist through a hatch or holes drilled in Perspex? How different does it feel if you are offered a cup of tea when you arrive? If the letter you are sent offering you an assessment says something about what this might entail and what a 'Community Mental Health Team' is? While it is important to convey the message that violence cannot be tolerated, there are lots of ways of doing this. For example, in a ward in a state hospital in the USA, the notice read *"We understand that you may feel frustrated and angry at times. If you feel like this, come and talk to a member of staff – we are here to help. Our job is to keep everyone safe. Violence will be prosecuted."*

SUPPORTING MENTAL HEALTH WORKERS IN DEVELOPING THEIR RECOVERY FOCUSED TALENTS

Individual supervision and appraisal

Teams need to empower staff to work in a more recovery-oriented way. It is important to create a context in which they can develop and grow – explore all facets of their practice and contribute to their full potential. In this context, supervision and appraisal that discuss, support and encourage recovery-oriented practice are central. How can we better develop relationships that reflect our common humanity and enable people to develop and grow? How can we think about the language we use and the way in which we understand people's challenges? How can we explore different ways of understanding why someone behaves and feels the way they do – how might things look from their perspective? How can we explore the way we do things – from initial assessments to ongoing individual work – to better foster hope, enable people to do the things they value in life and become experts in looking after themselves?

> *"Contrary to previous research on patients' experiences, the themes that predominated related to the emotional not physical environment in which they stayed ... relationships form the core of service users' experiences of psychiatric hospital admission ..."*
> (Gilburt, et al, 2008)

Such supervision and appraisal needs to involve both the celebration of success and addressing challenges. We must learn from success as well as from that which is not working well. It is as important to explore why some relationships are successful - and what has contributed to this success – as well as examining how challenges might be addressed. Indeed the former can inform the latter.

Some services have used the '10 top tips for recovery focused practice' as the basis for recovery focused supervision[2]. This list provides clear guidance for recovery focused conversations and a useful structure for identifying approaches and techniques that the individual might want to develop or improve (see Figure 1).

2 http://www.imroc.org/what-is-recovery/recovery-top-tips/

Figure 1: Ten top tips for Recovery focused interactions

After each interaction, the mental health professional should ask her/himself/themself, did I…

- actively listen to help the person to make sense of their mental health problems?
- help the person identify and prioritise their personal goals for recovery – not professional goals?
- demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?
- identify examples from my own 'lived experience', or that of other service users, which inspires and validates their hopes?
- pay particular attention to the importance of goals which take the person out of the 'sick role' and
- enable them actively to contribute to the lives of others?
- identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of their goals?
- encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)?
- discuss what the person wants in terms of therapeutic interventions, e.g. psychological treatments, alternative therapies, joint crisis planning, etc., 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 in working together, indicating a willingness to 'go the extra mile'?
- while accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self defined goals – maintaining hope and positive expectations?

(cited in Shepherd, Boardman, & Slade, M., 2008, p.9)

The possibility of introducing 360 degree appraisal at team level might also be considered, including the experience and contribution of people who are using the service in this process. For example, feedback might be provided by using the INSPIRE assessment tool (Williams et al., 2011) which focuses on the relationship the person has with a mental health worker and the extent to which they feel this supports their recovery as part of a person's appraisal. Alternatively, people who use services might be trained to provide clinical supervision with groups or teams of staff.

Recognising and rewarding individual expertise and effort

Recognition and reward for achievements is critical and cannot be left to supervision and appraisal alone.

In their 'effort-reward' model of job stress, Siegrist et al (1990) describes the problems that arise if effort and reward are out of balance; people are working very hard and receive little acknowledgement or reward for their efforts then well-being, morale and health are compromised. Reward in this context is not all about pay – it is also about status and recognition. Clearly pay and promotion are one way of recognising achievements, but alone they are a rather crude and infrequent mechanism that ensure that most people's efforts, most of the time, go unacknowledged.

Some services have recognised this by instituting various forms of awards for teams. While these may be an important way of acknowledging success, they too are infrequent and leave the day to day initiatives and successes of most staff uncelebrated.

Little things make a big difference and are the building blocks of recovery-oriented culture and practice. These little things often take a great deal of effort and ingenuity that goes unacknowledged. If no-one recognises the effort you are making then you rapidly stop making the effort. What motivates most of us is the sense of having achieved something – made a difference. If the effort-reward imbalance is to be restored then it is critical to acknowledge these successes. We need to build in ways of recognising and celebrating these day to day successes and relationships as part of our routine work.

On a day to day basis, simply noticing what others in the team have done is critical. A simple 'well done' or 'thank you' from a colleague or team manager can go a long way. Reflective practice sessions, care plan review meetings, ward rounds and staff handovers offer a real opportunity to do this. Typically these are problem-focused: problems are identified and solutions sought. If the course of action decided is successful it is rarely noted, we simply move on to the next problem. This leaves everyone with a sense of failure 'nothing we do works'. In order to recognise and celebrate success, some teams have started identifying a specific time in review meetings and ward rounds for discussing successes and exploring what can be learned from these. One ward decided to finish the handover at the end of each shift by going round and asking each staff member to describe something that they had achieved in the shift: a success, however small, or something of which they were proud. This not only recognised what staff had achieved but it left them going home after work on a positive note. Similarly, the manager of a community team instituted a 'little miracles' meeting at the end of each week. Towards the end of a Friday afternoon, all team members of the team who could make it were invited to come together for 'tea and cakes' and share the 'little miracles' that had happened during that week: these were written down on a sheet of paper and left on the wall as a reminder for the rest of the week. Tokenistic as such initiatives may sound, their impact on enabling people to recognise what they have achieved should not be underestimated.

As well as celebrating success within teams, it is important that these successes are recognised at a management level. Too often middle managers feel besieged from all sides – told from on high to make sure that cost and performance targets are achieved and from below that there are insufficient resources. Managers are more likely to recognise success if they know what individuals and teams have achieved. How often do individuals and teams feed-back their small but important success stories to offer a different narrative to that of performance targets? Providing feedback on the things that are important can do much to create a more recovery-oriented discourse within the service that can do much to change culture.

This might be achieved via newsletters that contain brief reports of progress and success in individual work with individual people using services. For example, one 'snippet' related how someone on an admission ward had refused to have a bath or wash: numerous confrontations and abuse followed when the person was repeatedly exhorted to bathe and relationships deteriorated. A member of staff spent time talking to the person and discovered that she thought it was unhygienic to bathe in facilities used by lots of strangers and ascertained that she would be happy to have a bath in her own home … so when the ward was quieter at a weekend the staff member took the person to her home to have a bath. One organisation started including narratives of success as a routine part of its Key Performance Indicator reporting systems. At the start, some cynics thought that these would go unnoticed – that 'they' would only be interested in the numbers, not the people. This proved wrong: the brief narratives brought the figures to life and reminded managers and commissioners what the service was really about.

As well as acknowledging achievements, recognising and using expertise of individual staff is also important both in making services more recovery oriented

and improving job satisfaction. Staff often have a range of professional training and experience (for example, working with families, addictions, trauma informed care etc.) which they are not able to use in their day to day work. In many teams, people only work with their designated 'caseload', so the input available to people using the service depends on the skills of their designated care co-ordinator. This is both a waste of skills and limits the options available to people using services. We need first to have a register of the skills that are available within the team and second, ways of enabling people using the service to access the skills within the team that they need. The creation of 'lead' roles can go some way to addressing this. For example, someone with family work training might be the 'family, friends and carer' lead and offer family interventions offer this to people across the team, not just to those on 'their own' caseload. Staff also bring a range of other talents and expertise from outside their professional careers: interests, hobbies, community networks and contacts and a range of cultural competencies. Staff satisfaction, and the experience of people using the service, can be enhanced by recognising the talents and interests of staff and using these. For example, a nursing assistant had been a journalist in the country of her birth – once these skills had been recognised she worked with service users to produce accessible, 'plain English' leaflets about the ward and the activities/ supports available. A staff member who had qualifications as a personal trainer used these to help individual clients to develop their own, individual exercise regimes. Identifying staff interests and talents enables a matching of clients and staff with similar interests and backgrounds can create a 'win-win' situation by fostering improved relationships and improving job satisfaction.

Building on strengths at team level: Using Team Recovery Implementation Planning

While it is important that each mental health practitioner reflects on their own practice, we all work together in teams and the whole is more than the sum of its parts. To work together effectively to promote recovery, and support the endeavours of individual workers, the whole team needs to reflect on their purpose and approach.

A service cannot promote recovery unless recovery focused principles and practice are embedded and owned at the grass roots. We need to work together to create more recovery oriented services and bring together the collective expertise, creativity and ingenuity of those at the front line – both mental health workers and the people who use services – with that available among relatives friends and communities. The Team Recovery Implementation Plan (TRIP) offers a framework for doing this. Initially developed in Nottingham, it has been refined in use across the UK and beyond (see Repper and Perkins, 2013[3]). It has proved a useful approach to the development of recovery focused practice in the full range of services (from high secure settings through acute inpatient wards and community teams to voluntary sector services) and has assisted in breaking down 'them' and 'us' barriers by changing the relationship between staff and people who use services.

The TRIP is founded on co-production. It involves ***recognising people as assets and building on the strengths*** within the team: the resources of both staff and people supported by the service. It is founded on the principles of mutuality and reciprocity – breaking down barriers and blurring roles: staff and people using the service share responsibility for both designs and delivery of the plans. It ***extends the resource base*** by including peer, personal, professional and community networks. The service becomes a ***catalyst for change rather than a creator of change*** by enabling people to lead their own recovery and the development of recovery-oriented services and empowering people to develop a range of resources in peer networks and communities to support them in their journeys. Not only does coproduction result in better services by harnessing additional capacity and expertise it also promotes the recovery of those involved by enabling them to move from passive recipient of services to active agent.

3 http://nhsconfed.org/~/media/Confederation/Files/public%20access/ImROC_briefing6_TRIP_for_web.pdf

The TRIP involves four key components[4]:

1. ***Identifying assets:*** the resources that exist within the team among staff and people using the service: not just the experience of using/providing mental health services but a) 'hidden talents' (other skills, qualifications, interests, experiences) and b) contacts and networks within communities. For example, one Early Intervention Team had someone using the services who was interested in the development of 'apps'. Using this talent, and the team manager's knowledge of sources of funding, the team developed 'My Mind Western Trust' app[5] to support people with mental health conditions and help them take back control as part of their TRIP. In a ward in a secure psychiatric service, a band was formed using the musical talents of a number of staff and inpatients as part of their TRIP.

2. ***Benchmarking progress in recovery focused practice.*** Based on good practice statements drawn from the *Recovery Self-Assessment – Provider Version* (O'Connell et al, 2005) and ImROC's 10 Key Organisational Challenges (SCMH, 2010), teams discuss and rate their progress. This is a collaborative process in which staff and people using the service recognise and celebrate what they have achieved and identify ways of moving forward and building on what they have done. For example, one voluntary sector service had already introduced people using services onto interview panels and decided they could build on this by coproducing job descriptions and person specifications with people using the service.

3. At the end of the benchmarking process, front line staff and people using the service, alongside people who are close to them and community partners, come together to ***identify priorities and develop action plans***. These might best balance impact and ease of implementation by including some 'quick wins' and some longer term projects. The challenge is not just about 'doing more' it is about 'doing differently'. The range of targets identified by teams is extremely broad, from making waiting areas more recovery focused, to the collection of recovery stories, changing the format of review meetings, shared entries in notes, 'trip advisor' style ratings of community facilities, co-producing information booklets about the service; inviting external agencies to run activities on wards; changing the initial assessment letter to make it more friendly and give people information about what the assessment would entail and what questions would be asked … Whatever the priorities identified it is important that these are co-delivered. Each priority is co-led by a staff member and someone using the service, assisted by other staff, people using the service, relatives/friends and community partners/agencies as appropriate. Many teams have found that not everything has to be done by staff. Tapping the expertise of people using the service is equally important. For example, one community team have decided to provide an 'information corner' in their waiting room. Staff have not got the time to run this, but there are people using the service who are keen to help on a voluntary basis. The team has made available resources to collect information leaflets about a range of issues (from opportunities in the local community to self-help materials) and people using the service introduce people to these and help them to use them. There exist a wealth of talents among service users that can be tapped!

The TRIP has also been used by corporate services and non-clinical teams to help them focus on what coproduction means in their own area and how they can better support the development of recovery focused practice at the front line. For example, one Business Development Department set up a group of people who had used services to assist in tendering for new services; and one executive team decided to introduce 'recovery impact assessments' of all new policies and service developments; a Finance Department produced a 'simple to understand budget statement' for hostels so that this could be shared easily with staff and residents in deciding how some of the available budgets should best be spent; and an IT Department worked with people using services to enable them to have access to the organisation's intranet.

4 http://www.imroc.org/media/publications/imroc_team_recovery_implementation_plan-3/
5 https://itunes.apple.com/gb/app/my-mind-western-trust/id802203395?mt=8

Critically, Team Recovery Implementation Planning is not a 'one-off' exercise but an ongoing process of co-producing and co-delivering action plans. Neither is it a quality rating scale or a 'tick box' exercise but a way of supporting recovery-oriented ways of working in teams: an heuristic tool to promote collaborative, 'bottom up', service development. Just as recovery is about recognising and building on strengths, TRIP provides a framework for bringing together the wisdom and resources of staff, people using the service, those who are close to them and community partners to create an environment in which all can grow and develop. Experience suggests that it is the collaborative process of using TRIP, rather than the specific content of the action plans, that is most critical in creating a more recovery focused culture and practice and changing the nature of interactions within teams.

MAINTAINING AND DEVELOPING RECOVERY-ORIENTED PRACTICE: THE CENTRALITY OF LEADERSHIP

Whitley's (2009) research into the core components of Recovery focused services demonstrated the importance of recovery focused leadership. Although recovery is now a central tenet of policy and practice guidance for all professional groups, in order to be enshrined in organisational culture it needs to be an explicit part of a shared vision that is understood and clearly led at every level of the organisation.

The principles of recovery translate effectively into principles for leadership. If services are to realise the changes in conversation discussed in this paper then they need leaders who inspire **hope** and belief in the possibility of improving services; facilitate a sense of personal **control** or agency among staff in the development and delivery of recovery focused initiatives, and create **opportunities** for personal development based on strengths, interests and experiences. These characteristics bear an uncanny resemblance to 'transformational leaders' (see Bass, 1997; Burns, 1978) who are recognised by their commitment to working with their organisation/team to identify needed change, creating a vision to guide the change through inspiration, and implementing the change in tandem with committed members of a group. Unlike transactional leaders who work within the status quo, transformational leaders strive for culture change to drive improvement and performance and stir their employees to look beyond their own self-interest for the good of the group (Investors in People 2017).

Bass (1997) identified four key components of transformational leadership. These have direct relevance to leading recovery focused culture change:

Idealized Influence - *the leader serves as an ideal role model for followers; the leader "walks the talk," and demonstrates the aspired behaviours of the whole team consistent with the overall vision*. Within any mental health team, the influence of a leader who clearly models recovery focused behaviour; prioritises the needs of people using the service over paperwork, explicitly appreciates the contributions, ideas and achievements of staff members; always uses recovery focused language and maintains a strengths based perspective, is invaluable in transforming the culture.

Inspirational Motivation - *Transformational leaders have the ability to inspire and motivate followers*. By embodying recovery principles even in the most stressful situations, displaying an unwavering belief in the potential of people, recognising the challenges of competing demands but consistently seeking creative solutions, the transformational leader motivates others to share their beliefs and actively change their own behaviours.

Individualized Consideration - *Transformational leaders demonstrate genuine concern for the needs and feelings of their team*. This appreciative approach chimes with the strengths based and personalised aspects of recovery. If every member of the team feel that they are valued and supported as an individual then they are empowered to perform to their full potential.

Intellectual Stimulation - *the leader challenges followers to be innovative and creative* and constantly seeks higher levels of performance. Although transformational leadership has been criticised for being too 'soft', in reality it is about constantly striving to achieve a shared vision and ensuring that everybody is fully committed to this: challenging their mindsets, ideas and beliefs to drive growth and performance, encouraging creativity, collaboration and the pursuit of excellence.

Whilst critiques of transformational leadership focus on the possibility of dependence on the leader and the need for a certain personality type to take up this role, research demonstrates the effectiveness of the approach. Transformational leadership is associated with greater leader effectiveness, higher staff commitment, role clarity and wellbeing and more positive outcomes than other leadership styles (Investors in People, 2017).

CONCLUSION

Although the culture of any organisation is highly influenced by the values and aspirations of Senior Managers, we contend that the experience of people using services is crucially dependent on the values, behaviours and beliefs of all practitioners. In order to change the conversation at the front line, it is essential to recognise, celebrate and develop both people who use services and the staff members with whom they have closest contact. It is also essential to develop relationships with community resources and facilities so that people using services have opportunities to build roles, relationships and meaningful lives beyond services.

All of this requires a a shift in priorities, practices and critically relationships so that everyone's contribution is valued and there exists a collective vision that is owned and shaped by people working in and using services, their family members and the communities in which they live. This inclusive, valuing and supportive culture needs to place an emphasis on strengths and achievements and learning from success rather than problems and things that have not worked out as we had hoped. It replaces excluding, technical, pathologizing and professionalised language with personal, accessible, appreciative conversations. Relationships are underpinned by courtesy, respect and mutual learning. A recovery focused culture is led at every level, in every part of the service with genuine partnership and value afforded to everyone who uses the service and works in it.

REFERENCES

Bass, B. M. (1990). From transactional to transformational leadership: Learning to share the vision. *Organizational Dynamics,* (Winter): 19-31

Boorman, S. (2009) *NHS Health and Well-being Review. Interim Report,* London: Department of Health

Burns, J.M (2010) *Leadership. Harper Perennial Political Classics*

Deegan, Patricia E. (2005) The importance of personal medicine: A qualitative study of resilience in people with psychiatric disabilities *Scandinavian Journal of Public Health*. **33** (66 suppl): 29–35.

Dunlop, B.J., Woods, B., O'Connell, A., Lovell, J., Rawcliffe-Foo, S. & Hinsby, K. (2021) Sharing Lived Experiences Framework (SLEF): a framework for mental health practitioners when making disclosure decisions. Journal of Social Work Practice https://doi.org/10.1080/02650533.2021.1922367 Accessed 7.7.21

Department of Health (2011) *The Public Health Responsibility Deal,* London: Department of Health

Department of Health (2015) *The NHS Constitution,* Department of Health

Dorset Wellbeing and Recovery Partnership (2013) *Framework for Using and Sharing Our Lived Experience within Health and Social Care*. Dorset Healthcare NHS Foundation Trust and Dorset Mental Health Forum. http://www.dorsetmentalhealthforum.org.uk/pdfs/other/supporting-staff-recovery.pdf

Gawande, A. (2014) ^The Idea of Wellbeing. Lecture 4 in the Reith Lectures 2014: The Future of Medicine, Indian International Conference Centre New Delhi, 20th December 2014

http://downloads.bbc.co.uk/radio4/open-book/2014_reith_lecture_4_delhi.pdf accessed 25/9/2021

Investors in People (2017) https://www.investorsinpeople.com/transformational-leadership-what-is-it/ accessed 17 September 2018.

Perkins, R. (2021) *Valuing and using personal experience in IPS practice*. London: IPS Grow

Perkins, R., Rinaldi, M. & Hardisty, J. (2010) Harnessing the expertise of experience: Increasing access to employment within mental health services for people who have themselves experienced mental health problems, *Diversity in Health and Care*, 7, 13-21

Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R. and Rennison, J. (2013a), *Peer support workers: theory and practice* ImROC briefing paper, London: ImROC, NHS Confederation Mental Health Network/Centre for Mental Health, London. http://www.imroc.org/media/publications/

Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R. and Rennison, J. (2013), *Peer Support Workers: a practical guide to implementation,* ImROC briefing paper, London: ImROC, NHS Confederation Mental Health Network/Centre for Mental Health, London. http://www.imroc.org/media/publications/

Seligman, M. E. P. (1972). "Learned helplessness". *Annual Review of Medicine*. **23** (1): 407–412.

Shepherd, G. Boardman, J. and Slade, M. (2008) *Making Recovery a Reality*. Nottingham: ImROC/London: CMH)

Whitley, R., Gingerich, S., Lutz, W.J. & Mueser, K.T (2009) Implementing the illness management and recovery program in community mental health settings: facilitators and barriers. Psychiatric Services, **60**, 202-209.

ImROC's Vision

For systems, services and cultures to support Recovery and wellbeing for all locally, nationally and internationally.

ImROC's Mission

ImROC works in partnership with communities to develop systems, services and cultures that support recovery and wellbeing for all. ImROC has been leading the way in recovery-oriented service and practice improvement since 2011.

Originally established on behalf of the Department of Health to champion its 'Supporting Recovery' initiative, through a collaboration between the Centre for Mental Health and the NHS Confederation's Mental Health Network, ImROC is now hosted through Nottinghamshire Healthcare NHS Foundation Trust. This innovative new partnership allows us to cement our close working relationship with frontline providers of care, ensuring that our work remains relevant and useful to practitioners, managers, system leaders, local communities and ultimately, the people who access services.

Our role is about enabling people (who use services, work in services and live in communities) to unlock and pool the strengths and talents they take for granted, explore new ways to make use of them, share knowledge and learning, and facilitate recovery-oriented improvement in the outcomes and experience of health and social care. We rely on and embrace the expertise, experience and collective wisdom of everyone we work with, and encourage communities to develop as a result. Our job is about using our expert knowledge to inspire others to believe that change is possible; pursue their dreams, and most importantly to act: changing attitudes and behaviours. This ethos of working in co-production is at the heart of our organisational work, and role models what we seek to achieve at a practice level too.

Contact:

ImROC Head Office
PO Box 11115
NOTTINGHAM
NG14 6UZ

imroc@imroc.org
www.imroc.org

Citation: Perkins, R., Repper, J. Giles, K (2022)
Changing the Conversation …….
ImROC Briefing Paper 19. Nottingham: ImROC.