NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

BEHAVIORAL HEALTH WORLD SERIES

Webinars

Peers as Partners: How England's Recovery Colleges Are Changing the Culture

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Supporting recovery in England

Mental Health policy (DoH/HMG, 2011)

Contains 6 objectives:

Objective ii. – More people with mental health problems will recover

Defines recovery in terms of the achievement of life goals, not 'clinical' Recovery

Implementing Recovery through Organisational Change (ImROC)

- A 3yr. project, mainly funded by Department of Health, to assist local services be more supportive of recovery
- Led by a project team consisting of experienced practitioners, researchers and service users
- Delivered by an independent mental health charity (CMH) and an organisation representing senior NHS managers (NHS Confederation)
- Worked with over half the services in England (n=29)
- On each site involved mental health providers, user and carer organisations *and* independent sector providers

2 central questions:

1. How to change the **attitudes and behaviour of staff** and teams so as to make them more supportive of recovery?

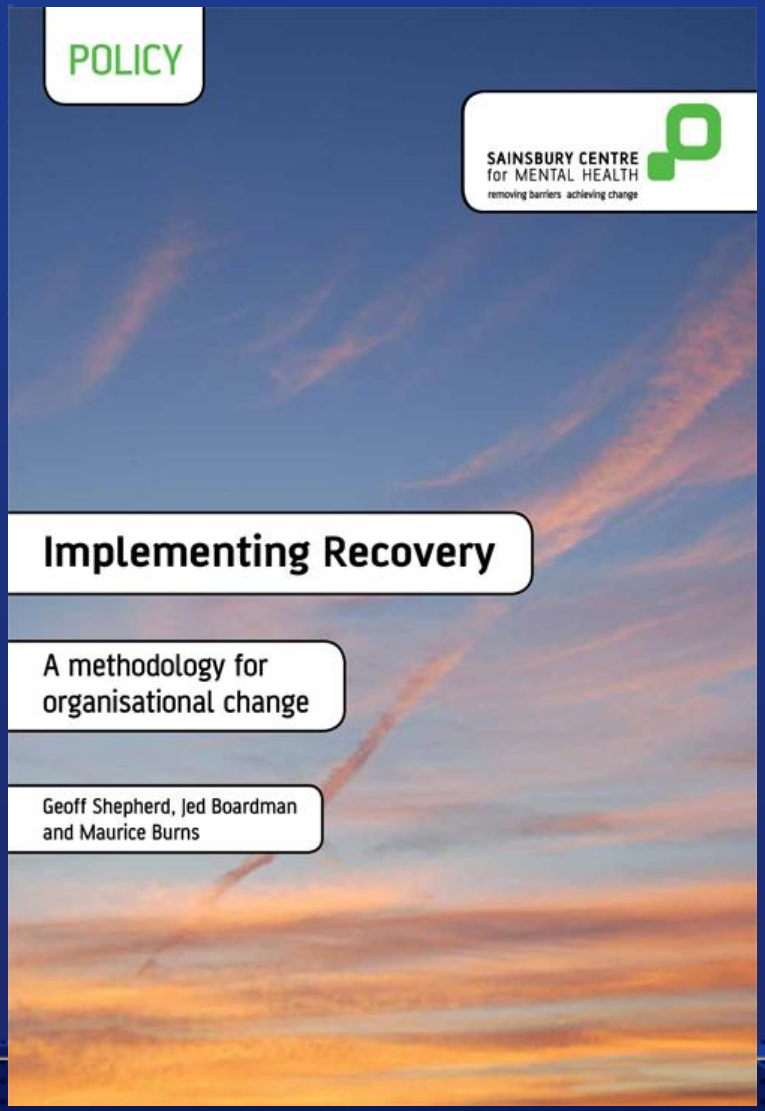
2. How to **change the organisation** such that these changes in staff behaviour are supported and maintained? (changing the 'culture')

Developing the methodology

- Identified 5 NHS Trusts and their local partners who had already made significant progress
- Ran a series of local workshops, involving more than 300 staff, service users, family members and managers
- Formulated a list of ‘***10 key Organisational Challenges’*** deemed necessary in order to move towards more ‘recovery-oriented’ services.
- Developed a methodology based on agreeing targets and methods of measurement, implementing change and reviewing progress (i.e. a closed ‘audit loop’)

The 10 'key challenges'

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user-led education and training programmes
3. Establishing a 'Recovery College' to drive the programmes forward
4. Ensuring organisational commitment, reviewing policies and procedure, ensuring effective leadership at all levels
5. Increasing 'personalisation' and choice
6. Transforming the workforce
7. Changing the way we approach risk assessment and management
8. Redefining user involvement – moving towards true 'partnerships'
9. Supporting staff in their recovery journeys
10. Increasing opportunities for building a life *'beyond illness'* , e.g. work


POLICY
SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change
Implementing Recovery
A methodology for
organisational change
Geoff Shepherd, Jed Boardman
and Maurice Burns

ImROC - activities

- Provided 100 on-site 'technical consultancy' visits, usually senior member of the team + 'expert-by-experience'
- Jointly delivered more than 50 training sessions, attended by more than 400 staff, service users, team leaders + 'middle' managers
- Run 24 x 1 day workshops, grouped into 4 'Learning Sets'

The 'Learning Sets'

- Each site is a member of a 'Learning Set' along with 5/6 other sites. They meet for 6 x 1 day workshops over the course of the project (i.e. approx. 3-4 months apart).
- Each site can send up to 8 people to the workshop, with a mixture of professionals and service users (and carers)
- The topics for the Learning Set have been pre-chosen by the members.
- Each workshop consists of formal presentations by experts, followed by users' comments and discussions in which members can share their experiences and learn from one another ('market stalls')

Changes in services

- Helped develop local, inter-agency strategies to identify priorities and begin implementation
- Supported reviews of risk assessment procedures and progressed towards 'safety planning'
- Established 7 *Recovery Colleges*, each offering more than 50 'co-produced' courses for staff and consumers. 3 more due to open soon
- Supported the training, placement and support of approx. 150 *Peer Support Workers* across 12 sites

What have we learned?

- Change is possible – even in these difficult financial times – but it must be driven by a strong partnership between staff and service users (consumers) and families

- Training is not enough on its own! Sustainable change depends on changing the ***organisation*** as well as changing staff attitudes and behaviour 'on the ground'

- Leadership is critical, but leadership is distributed throughout organisations, it is not just at the 'top' (or the bottom)

- The most powerful changes have been in staffing and the inclusion of more people with lived experience (peers) into the workforce

Peer Support workers – their unique contribution

- *The clear distinction between Peer Support Workers and other roles is* ***the explicit requirement to draw upon and share their own experiences of emotional distress and/or of using mental health services*** *in order to inform, inspire and support others in similar situations.*

Types of peer support

- '**Informal**' – natural support from friends, volunteers, etc. Has a very long history (Davidson *et al.,* 2012)
- '**Formal**' posts working inside local mental health services - employed after training, with contracts, JDs, management support, supervision, career progression
- **Peer run services** – working relatively independently of local services, may be 'formal' in other respects

Peer roles within MH organisations

- Staff selection
- Quality monitoring
- Advising on service development priorities
- Providing services, e.g. working in teams alongside traditional professionals
- Training staff, e.g. Recovery Colleges

Effectiveness of peers
(Repper & Carter, 2010)

- Increased hope inspired by meeting people who have overcome similar difficulties
- Increased sense of empowerment
- General psychological and social benefits of being employed – increased self-esteem, confidence, etc.
- Improvements in quantity and quality of social relationships
- Limited controlled trial evidence, but most studies find reductions in re-hospitalisations and bed days by up to 50%
- In these cases peer workers can be highly ***cost-effective*** (cost benefit ratio of more than 2:1)

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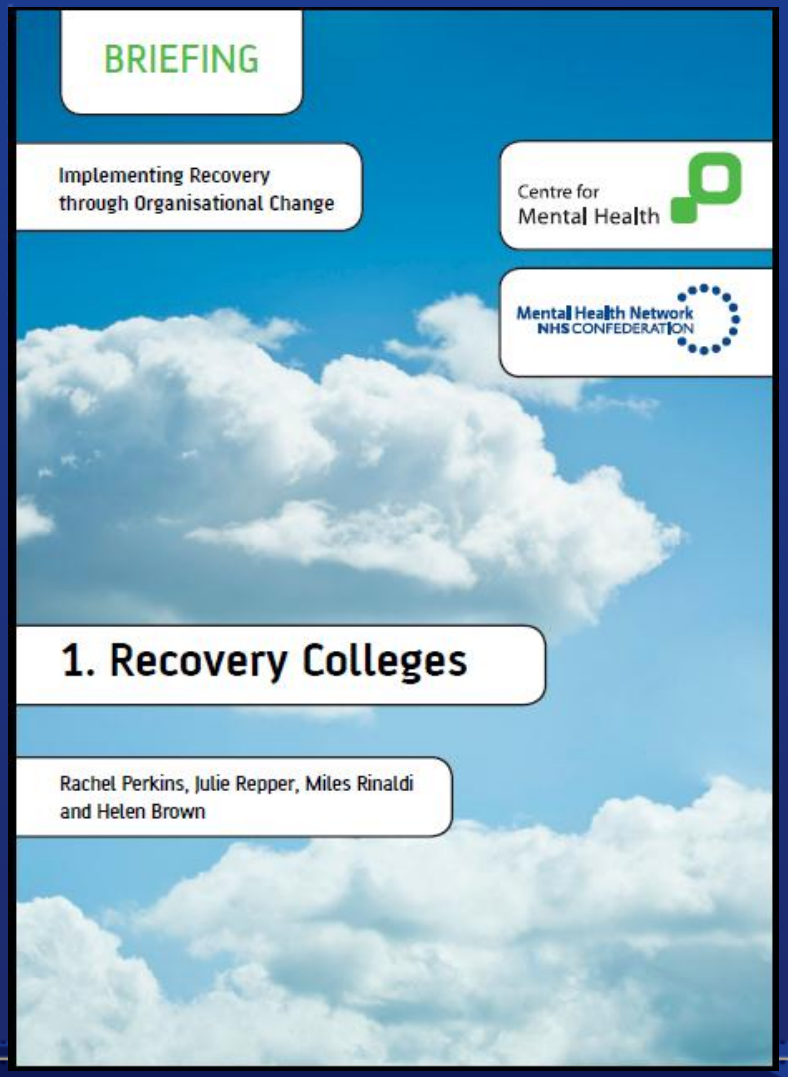
BRIEFING
Implementing Recovery through Organisational Change
Centre for Mental Health
Mental Health Network NHS CONFEDERATION
1. Recovery Colleges
Rachel Perkins, Julie Repper, Miles Rinaldi and Helen Brown

Where did the idea come from?

(**Lori Ashcraft, *Recovery Innovations*, 2000**)

"*We decided to use education as the model for promoting Recovery, rather than develop more traditional treatment alternatives. ……*

We did this because we wanted our Centre to be about reinforcing and developing people's strengths, rather than adding to the attention on what is wrong with them……...

People will discover who they are and learn skills to find out what they can be"

Table 2 – A Recovery College is not a day centre

From Day centre	To Recovery College
Patient or client: *"I am just a mental patient"*	Student: *"I am just the same as everyone else"*
Therapist	Tutor
Referral	Registration
Professional assessment, care planning, clinical notes and review process	Co-production of a personal learning plan, including learning support agreed by the student
Professionally facilitated groups	Education seminars, workshops and courses
Prescription: *"This is the treatment you need"*	Choice: *"Which of these courses interest you?"*
Referral to social groups	Making friends with fellow students
Discharge	Graduation
Segregation	Integration

What are the benefits?

a) Benefits to those using the service

b) Benefits to those delivering the service

c) Benefits to teams

d) Benefits to the organisation.

Direct benefits to service users

Rinaldi *et al*. (2012) SW London 2011/12, over 1000 students attended courses (44% with a diagnosis of schizophrenia)

- 62% completed >70% of the course.
- 68% felt more hopeful as a result of attending
- 70% had become volunteers, mainstream students or employed
- 81% had developed their own plans for staying well
- significant reductions in use of community services

Benefits to the Peer trainers

- *"Undertaking the peer employment training has been the single most valuable thing in my recovery journey. I still have challenges, but I now know how to deal with them. The fact that I am employed in a peer worker role has no doubt kept me well……"*

- *It's made a real big difference to me you know, just contributing to people and hopefully changing their lives for the better…".*

- *"It doesn't matter how long I work in Peer Support or how much training I do; I will never be the expert in somebody else's life. All it means is that I have some idea of where they are and I can talk with them about recovery. …."*

Impact on the teams

- *"I just stand back and watch him work his magic. Not just with the patients who come in here so frightened and hopeless, but with staff too. He can help them see things in a completely different way….." [Nurse]*

- *"Peer workers have significantly changed the recovery focus of our team, they challenge the way we talk about people and make us change from a 'problem' and 'diagnosis' focus to one of strengths and possibilities……" [Psychiatrist]*

- *When I first started going to meetings they (staff) were quite disrespectful about service users. Once they knew I was one they became much more positive and changed their language…" [Peer worker]*

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Impact on organisations

- Recovery Colleges provide a tangible symbol of the organisation's commitment to working with peers as full partners in care
- They provide a demonstration that peers are people with ***real*** skills and knowledge and it isn't just staff who are the 'experts' in mental illness
- Peer educators are powerful role models – for staff and peers (and managers) – showing what can be achieved if people are given opportunities

Conclusions

- In the 21st century, now that the mental hospital has gone, we need a new relationship between those providing mental health services and those using them

- This must be a true **partnership,** based on mutual respect, and a recognition that both groups have important knowledge and expertise to contribute, but they need to work ***together***

- This has fundamental implications for the MH workforce, e.g. *'What should be the balance of 'staff experts' and 'peer experts'?* 50:50? 80:20? (in which direction?)

Perhaps this is a key question for the future?

Thank you

Geoff Shepherd

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