Developing a ‘model service’ to support recovery in mental health - implications for providers and commissioners

Chair: Professor Dean Fathers, Nottinghamshire Healthcare NHS Trust

Speakers: Professor Geoff Shepherd, ImROC
Lynn King, Iris Benson, Katharine Tyrer & Jenny Rob, Mersey Care NHS Trust
Developing a ‘model service’ to support recovery in mental health - implications for providers and commissioners

Professor Geoff Shepherd
ImROC Programme Director
National Policy

**2011**

Objective ii. – “More people with mental health problems will recover” [N.B. Defines ‘Personal Recovery’ not ‘Clinical’ Recovery]

**2014**

“#1. High-quality mental health services with an emphasis on recovery should be commissioned in all areas.”
Implementing Recovery through Organisational Change (ImROC)

- Began in 2009. Delivered by a partnership between the Centre for Mental Health and the Mental Health Network of the NHS Confederation

- Initially funded mainly by the Department of Health, now self-funded

- Aims to answer 2 key questions:
  1) How to change the attitudes and behaviour of staff and teams so as to make them more supportive of recovery for people using these services?
  2) How to change organisations such that these changes in staff behaviour are supported and maintained? (changing the ‘culture’)

Effective support for organisational change

- Worked with more than 25 sites (> half nationally), ‘systems’ approach involving all local stakeholders – MH provider (NHS), local independent sector organisations and user & carer groups.

- Delivered on-site consultancy days (peer + professional) to help review current progress and develop specific ‘recovery supporting’ interventions.

- Organised national ‘Learning Sets’ to provide opportunities for practical knowledge transfer and mutual support.


- Led major projects transforming mental health services in Ireland (Northern and Republic). International collaborations in Denmark, Norway, Italy (and Japan!).
Key service developments to support recovery

✓ Recovery Colleges

✓ Peer Support workers

✓ Moving from ‘risk assessment and management’ to person-centred safety planning

✓ Changing the culture on acute and locked wards by introducing recovery principles
Simple, evidence-based methodology for organisational change

- Identified ‘10 key challenges’ for organisations wishing to support recovery (but not relying on simple issuing of guidelines to achieve change).

- Also assumed that changing staff behaviour (training) will not be enough on its own (Whitley et al., 2009)

- Used a simple methodology based on agreed goal-setting, implementation and review (‘Plan-Do-Study-Act’ cycles). Most effective method for organisational change (Iles & Sutherland, 2001)

- Provided mutual support through ‘Action Learning Sets’ to sustain change and maintain innovation
‘Co-production’

A radically different way of thinking about mental health service delivery.

4 key elements:
✓ Recognising people as assets
✓ Valuing the contribution they can make
✓ Promoting reciprocity (to build trust and mutual respect)
✓ Building social networks

People receiving services thus become more than a bundle of needs to be met. They become part of the solution to the crisis in public services, not simply ‘the problem’ to be fixed
The Key Components of High Quality Recovery Orientated Services

Lynn King, Jenny Robb, Katharine Tyrer, Iris Benson
High Quality Recovery Orientated Services

As we have gained more experience in using the ImROC ‘10 Key Challenges’ four specific elements have emerged as being particularly important in terms of high-quality, recovery orientated services.

1. The application of recovery principles to improve the quality of care and safety on in-patient units (No Force First)
2. A move from professionally determined risk assessment and management to person centred ‘safety planning’.
3. The establishment of a Co-produced Recovery College – empowering self management and learning
4. Selecting, training and supporting Peer Support Workers – shifting the culture

Challenge - Building on the work and maintaining the momentum, sustaining in the current context of change.
‘NO FORCE FIRST’

Changing the culture to create coercion free environments.
A quick overview

• Initiative to fundamentally change how challenging behaviour was dealt with in mental health units in the US.

• Aims to change in-patient culture from one of containment to one of recovery.

• Sets force elimination as the ultimate goal.
Initial Plan

• Reach for the stars: reduce incidents of restraint to zero
• Link this to safeguarding & to Implementing Recovery through Organisational Change, (ImROC)
• Recruit champions from every service to plan and implement
• Identify Executive Sponsor and support from AqUA
• Set up Steering Group and Operational Group
Pilot wards identified

High Secure
Learning Disabilities
General Adult
Older People's
Medium Secure

these are only some of our sites!
Data Issues

• Reliability of baseline data particularly medication led restraint:
• Lack of Trust standard definitions of physical and medication led restraint
• Variability in reporting of restraint incidents due to differing perceptions of what constitutes restraint
• Adopted NICE guidelines for Physical restraint and took several months to agree standard project definition of medication led restraint
Implementation

• Staff engagement events: standard briefing and awareness session co-produced and delivered

• Quality Improvement Methodology to evaluate and measure improvement, (e.g. driver diagrams and PDSA cycles)

• Cycles include core evidence base interventions and those identified by staff team as a priority for their service area

• Results of PDSA cycles to Operational and Steering Groups: central monitoring and evaluation essential for future sustainability
Improving relationships: the heart of NFF

- **Demonstrate listening** – using ‘Advanced Statements’ and peer support

- **Show flexibility** – moving away from a ‘rule based’ culture

- **Show compassion and understanding** - behaviour always seen in the context of past events: trauma informed care

- **Patience** - careful interaction, respectful and compassionate, even during challenging periods

- **Positive, recovery focused, communication** - how we talk about service users strongly indicates how we value them
Changing culture through training...

Q. What are Management of Violence and Aggression trainers telling employees about challenging behaviour and the need for coercion?

R. “We all know what patients are capable of”
   “You always have to be on your guard”
   “Don’t take chances - you can get badly hurt”

Our MVA trainers use FRED A principles:

• Trauma informed perspective on challenging behaviour, recognising negative life experiences can generate it.
• Language: person-centred, compassionate and positive.
• Question any negative language used during training
• Teaching a range of physical interventions to meet a range of needs, actively promoting less intrusive and more dignified interventions.
Leadership – Pilot Wards

• Maintain an ‘Open office’ – service users warmly invited in for a chat. The office is not treated like a fortress.
• Instantly remove staff from a fraught situation if interventions are likely to generate a non-coercive response.
• Active on the ‘shop floor’ to mediate between disputing parties at fraught times.
• Openly demonstrates relaxed and respectful inter-personal relationships with service users.
Leadership: from Containment to Recovery

- Articulate a ‘No Force First’ vision to all staff: hold them accountable for the quality of their interactions.
- Describe the use of force and coercion as a treatment failure.
- De-briefing, including service user, whenever force is used.
- Ensure nurse bank and agency staff are aware of the vision - they may have worked in areas with a different approach.
- Characterise relationships with service users as ‘risk sharing’ partnerships - rather than ‘risk management’ control.
- Use peer support.
- Use advance statements & trauma informed care.
Impact to date: Physical Restraint

Restraints on All Pilot Wards

- Upper Control Limit
- All Pilots
- Baseline
- Actual Performance

April 12 to March 14
Sustaining Improvement

- Bottom up and top down support
- Promoting achievements
- Telling stories of service user and staff experience
- Research and evaluation
- Planned roll out of evidence based PDSA cycles
- Continuous measurement and evaluation of improvements: on-going development of balancing measures
- Support from National ImROC Learning Sets
- Shift in workforce (Peer Support Workers)
- More Recovery Education for service users and staff
Lessons Learned – the *importance* of ... 

- Connecting to the strategic vision
- Visible support from the Board
- Credible evidence base and rationale for improvement
- Use of QI methodology and measurement
- Collecting reliable data
- Leadership (having local ‘champions for change’)
- Involving people who use services in co-production and co-delivery
‘CO-PRODUCED RECOVERY COLLEGE’

Empowering & supporting self management and learning
Recovery Colleges

18+ Recovery Colleges, each offering up to 50 ‘co-produced’ courses on different aspects of living with mental illness for service users, staff and families

- Two-thirds of those registering completing >70% of courses
- 80% developed own plans for staying well
- 65% reported increased hope for the future
- 70% moved on to become volunteers, mainstream students or employed
- Significant reductions in use of community services (CMHTs)
Mersey Care Recovery College

• Through the recovery college we are aiming to enable people to recognise, develop and make the most of their talents, skills and resources in order to develop expertise in their own recovery and well-being and to live the best lives possible for them.

• The courses should complement and enhance traditional treatment and support.

• We want to further break down barriers by developing and delivering learning opportunities and courses by people with lived experience and our staff and partners with professional experience.
Mersey Care Recovery College Courses

Mersey Care Recovery College Prospectus 2013-2014

31 courses over 5 key areas:

• Understanding a condition
• Rebuilding a life
• Developing life skills
• Building peer workforce
• Support for family, friends and carers

www.merseycare.nhs.uk/info/imroc/recoverycollege
A Different Relationship Between Services & Communities

Mental health services and expert professionals can sometimes unwittingly perpetuate exclusion in a vicious cycle:

- We need to empower people and communities to discover, develop and use their own resourcefulness.

People with mental health, addiction and learning disabilities (and families, and the public) believe that experts hold the key to our difficulties.

And we become less and less used to finding our own solutions and embracing distress as a part of ordinary life.
Confidence Building Through Drama

A creative workshop to help you:
Increase your self expression and personal development
Improve your communication
Overcome shyness
Increase trust

Fridays 10.00pm-12.00pm
Starting 24th April 2014
May Logan, Knowsley Road, Bootle, L20 5DQ

For more course details and how to enrol contact:
Email: Recovery.college@merseycare.nhs.uk, Tel: 0151 330 4140
Or visit: www.merseycare.nhs.uk/info/imnc/recoverycollege

25th, 27th and 28th March 2014 10.00-12.00pm
Rathbone Learning Suite, Mill Lane
Wavertree, L13 4AQ

Self-esteem Building

Understanding a Diagnosis of Personality Disorder

Monday 27/3/14 1.00pm-4.00pm @ Parthenon Resource Centre

Students will cover what is meant by personality disorder in general and the impact of having a diagnosis. The workshop also covers how personality disorders may influence other aspects of a person’s physical and mental health. Also covered are specific treatments as well as how people can help themselves to regain some control in their lives.

For more course details and how to enrol contact:
Email: Recovery.college@merseycare.nhs.uk
Tel: 0151 330 4140
Or visit: www.merseycare.nhs.uk/info/imnc/recoverycollege

May Logan
Knowsley Road, Bootle, L20 5DQ

Starting TUES MAR 18

TREASURE YOUR WELLBEING

Keep learning - Take notice - Give
Keep learning - Be Active - Connect

Using the 5 ways to wellbeing to create your very own Treasure chest

7 week course
Starting Tuesday 18/3/2014

For more course details and how to enrol contact:
Email: Recovery.college@merseycare.nhs.uk
Tel: 0151 330 4140
Or visit: www.merseycare.nhs.uk/info/imnc/recoverycollege

Living Life to the Full

Tuesdays 1.00pm-3.00pm
Starting 6th May 2014
May Logan, Knowsley Road, Bootle, L20 5DQ

For more course details and how to enrol contact: Recovery.college@merseycare.nhs.uk, 0151 330 4140
Or visit: www.merseycare.nhs.uk/info/imnc/recoverycollege
What students are saying?

Results of students satisfaction survey:

The course’s content was relevant and reached my expectations
96% either agreed or strongly agreed

I now feel more hopeful for the future as a result of this course
83% either agreed or strongly agreed

I feel I will be able to do the things I want to do in life as a result of this course
83% either agreed or strongly agreed

I found the booking procedure straight forward
97% either agreed or strongly agreed

I intend to tell others that this course is worthwhile
88% either agreed or strongly agreed
Peer Support Workers

- 150+ Peer Support Worker posts (paid, mostly part-time)
- 80% working alongside professionals in teams, the rest as ‘Peer Trainers’ in Recovery Colleges
Definition

Peer support is “offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations”
Establishing Peer Support Workers – 4 Phases

1. Preparation
   - The organisation
   - The teams
   - Defining Roles and developing job descriptions
   - Preparing the peers (learning and development)

2. Recruitment
   - Advertising
   - Benefits advice
   - Applications
   - Interviews
   - Occupational health
   - CRB checks
   - Supporting those who may not be offered a post

3. Employment
   - Matching roles and peers
   - Induction & orientation
   - Supervision & support
   - Maintaining wellbeing

4. On-going Development of the role
   - Career pathways
   - Training opportunities
   - Wider system change
Recovery & Our Strategy

- No Force First – application of Recovery Principles to improve the quality of care and safety on our in-patient units
- Moving from risk assessment and management to person centred safety planning

Perfect Care

- Selecting, training & supporting Peer Support Workers
- Hope
- Control
- Opportunity

Better Services

Co-production - Work side by side with people
Pathways to employment and meaningful occupation

Our Organisation

Partnerships that build social capital and recovery
Sustaining and growing our Recovery College

Partnerships
“Taking Responsibility of my life has given me control of my future. It’s a wonderful feeling knowing that I am in charge of my own destiny.”

Frances
So,

1. What kinds of outcomes can we expect from services designed to support recovery?

2. Will it cost huge amounts of money?
I. Quality indicators – at an individual and organisational level

II. Outcome indicators - 6 domains identified by expert stakeholder group
## Recovery Outcome Domains (after DH expert group)

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>TITLE</th>
<th>RECOMMENDED MEASURE</th>
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<tbody>
<tr>
<td><strong>Definite</strong></td>
<td></td>
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<tr>
<td>1.</td>
<td>Experience of care</td>
<td>INSPIRE</td>
</tr>
<tr>
<td>2.</td>
<td>Individual recovery goals</td>
<td>GAS</td>
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<tr>
<td>3.</td>
<td>Subjective measures of personal recovery (hope, meaning, connectedness, etc.)</td>
<td>QPR</td>
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<td>4.</td>
<td>Socially valued goals (accommodation, employment, social integration)</td>
<td>ASCOF, Social Inclusion Web</td>
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<tr>
<td><strong>Possible</strong></td>
<td></td>
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<tr>
<td>5.</td>
<td>Quality of life, Well-being</td>
<td>MANSNA, WEBWMS</td>
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<tr>
<td>6.</td>
<td>Service use</td>
<td>MHMDS, NHS Outcomes</td>
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Domain 1: Experience of care – the INSPIRE tool

[http://www.markslide.com/refocusstudies#inspire]

- 21 item questionnaire filled in by the service user on the basis of her/his contact with the staff member whom they judge to be most important in supporting their recovery.

- Each item is rated on a 5 point scale, with an option to indicate that a specific area of support is not relevant to the individual. Contains 2 sub-scales; (a) ‘Support’ and (b) ‘Relationships’

- Good face validity. Relatively quick and easy to use (generally takes about 10 mins. to complete)

- Short version now available
Slade (personal communication) suggests that INSPIRE could be shortened to 5 items using the CHIME framework (Leamy et al., 2011)

<table>
<thead>
<tr>
<th></th>
<th>A brief version of INSPIRE</th>
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<tbody>
<tr>
<td>1</td>
<td>My worker helps me to feel supported by other people [C]</td>
</tr>
<tr>
<td>2</td>
<td>My worker helps me to have hopes and dreams for the future [H]</td>
</tr>
<tr>
<td>3</td>
<td>My worker helps me to feel good about myself [I]</td>
</tr>
<tr>
<td>4</td>
<td>My worker helps me to do things that mean something to me [M]</td>
</tr>
<tr>
<td>5</td>
<td>My worker helps me to feel in control of my life [E]</td>
</tr>
</tbody>
</table>
The relationship between Quality of Life & Well-being

- **Connell et al., (2012)** - Synthesis of qualitative research on QOL for people with mental health problems, concluded that QOL and Well-being **not** the same

- **Quality of Life includes** mental Well-being, but also **includes**:
  - Physical well-being
  - Subjective sense of control
  - Feelings of hope
  - Feelings of autonomy and choice
  - Positive self-image
  - Sense of belonging
  - Engagement in meaningful activities

- Strong overlap with recovery dimensions – Hope, Control, Opportunity - hence, need for a new measure?
Domain 6: Service use

- Reduced service use may be a consequence of recovery, but simply reducing services doesn’t mean that people are necessarily more ‘recovered’.

- Recovery is about building a meaningful and satisfactory life, this is difficult if the person is in hospital repeatedly for long periods, hence reduced length and frequency of inpatient admissions, reduced repeat admissions, number of compulsory admissions, etc. are probably reasonable indicators.

- Reduced use of community services is more controversial. Might be considered as a recovery outcome indicators - but might not. Must be taken in the context of other outcome indicators.
What about the money?
Cost-effectiveness of peer workers

- Selected 6 controlled trials, 5 US + 1 Australian.
- All provided data on impact of adding trained peer workers to existing inpatient or community teams.
- Ratios of savings vs. expenditure calculated for using current NHS prices for workers and bed days.
- In 4/6 studies ratios extremely positive.
- 1 negative study; 1 positive, but ns.
- Overall weighted average (taking into account sample size) > 4:1.
Planning for the future (p.6)

[The importance of reducing bed use and preventing relapse…]

“…An approach which may also in time offer the biggest scope for cost savings in mental health care is to promote and expand co-production, drawing on the resources of people who are currently using mental health services, for example in peer support roles …

……[and] …… non-mental health agencies in the local community (education services, faith groups, hobby and leisure activities, friends, family, etc.) which in many cases may already be helping people with severe mental health problems, but could do much more if actively supported by mental health services”.

[Italics added]
A model for cost-effective, MH services to support recovery

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