ImROC
Implementing Recovery through Organisational Change

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Mental Health Network NHS CONFEDERATION

Research into Recovery Network (RRN)

Meeting, 6th November 2013

ImROC – An update

Professor Geoff Shepherd

ImROC Recovery Programme Lead

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Implementing Recovery through Organisational Change (ImROC)

- Began in 2009. Delivered by a partnership between the Centre for Mental Health and the MH 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')**

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What ImROC *isn't*

- An attempt by professionals to take over the processes of recovery
- A set of assumptions that everyone with mental health problems must lose their symptoms first (clinical recovery) *before* they can pursue their life goals (personal recovery)
- A belief that improving the support offered by mental health services is the best (or only) way of supporting peoples' recovery
- An attack on 'professionals' and 'treatment'
- An argument for entirely peer-led services
- A set of ideas that have no evidence to support them
- A justification for cutting services (although it may inform these decisions).

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Progress so far

- Worked with more than 40 sites
- Organised 42 Learning Sets attended by 1400 people
- Produced 7 Briefing papers (2 more in production)
- Run 6 webinars
- Helped to establish 14 Recovery Colleges each offering 5 – 100 courses, attended by thousands of people
- Advised on the creation of 150 Peer Support Worker posts (paid, but mostly part-time) 130 working in services, 25 'Peer Educators'
- Supported 7 Trusts to apply recovery principles in acute inpatient and secure settings with an aim of reducing incidents of seclusion and restraint ('*No Force First*').
- Preparing guidance on 'Secure Recovery'

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How has this been achieved?

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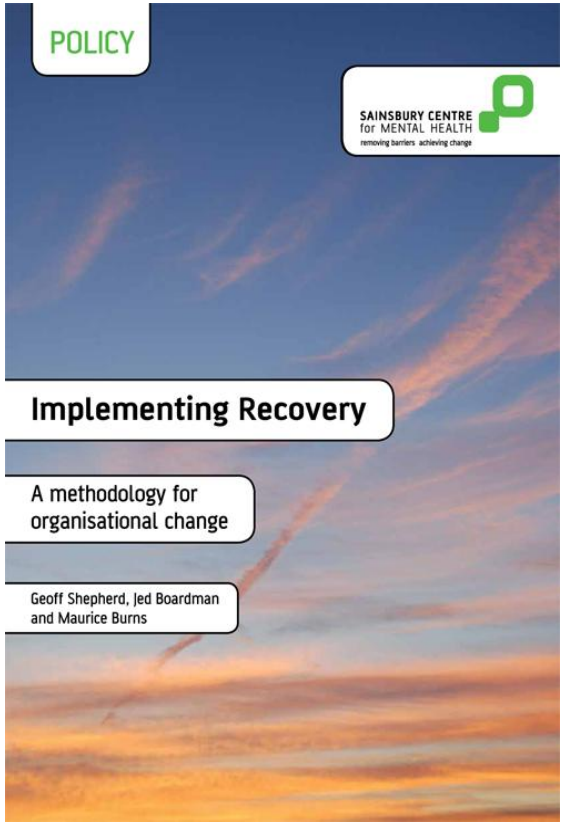
The ImROC methodology



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- Identified ‘10 key challenges’ for organisations wishing to support recovery
- Promoted partnerships between local health and independent (social) providers, user & carer groups to agree specific goals
- Used a simple methodology based on closed audit loops (P-D-S-A cycles) - joint agreement on goals, implementation, review, repeat – to produce change.
- Provided on-site support from a multi-professional expert team, including service user and carer consultants
- Used a ‘Learning Set’ methodology to maximise learning and provide mutual support for change.
- Creation of an interactive, collaborative peer network of recovery innovators and leads

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

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, 'co-produced' learning programmes
3. Establishing a 'Recovery Education Centre' (Recovery College) to drive the programmes forward using a co-produced, educational model
4. Ensuring organisational commitment, creating the 'culture'
5. Increasing 'personalisation' and choice
6. Transforming the workforce – peers in a variety of positions
7. Changing the way we approach risk assessment and management
8. Redefining user '*involvement'* to create genuine '*partnerships*'
9. Supporting staff in their recovery journey
10. Increasing opportunities for building, '*a life 'beyond illness*'

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"Kotters Eight Steps of Change"

[1] Kotter, John P. and Cohen, Dan S. The Heart of Change. Boston: Harvard Business School Press

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Changing organisations

(after Slade, 2009, chapter 26)

7 key principles:

1. Leadership (not management)
2. Articulate values and demonstrate consistency
3. Maximise pro-recovery orientation among workers
4. Develop pro-recovery skills in the workforce (strengths model, coaching, etc.)
5. Make role models visible
6. Amplify the power of consumers
7. Evaluate success

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1. Leadership is critical - but it is always dispersed

- Leadership has to be 'transformational'. [N.B. Don't be afraid of charismatic leaders].
- Look for leaders at all levels and from all backgrounds. Leaders work best together.
- Change requires effective project management at an operational level, supported by an appropriate strategy at an organisational level. If either is deficient, change will be impeded.
- Staff are part of the solution, <u>not</u> part of the problem

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2. Articulate values - the key principles (after Perkins & Repper, 2003)

- ***Hope*** – Maintaining a belief that it is still possible to pursue one's chosen life goals. **Hope is personal** and **relationships are central**

- ***Control*** – The importance of **personal meaning** and understanding. (Re)gaining a sense of control over one's life and one's symptoms. Having **choice** over the **content of interventions** and **sources of help.** Balancing **evidence** with **personal preference**

- ***Opportunity*** – The need to build a life 'beyond illness'. Being a part of the community ('**social inclusion**') not simply living in it. Having **access to the same opportunities** that exist for everyone else, e.g. with regard to **housing, employment, social support, etc.**

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3. Maximise pro-recovery among workers - The benefits of co-production for staff

- ✓ Involve staff, at all levels, from the beginning
- ✓ Work with service users to co-produce new understandings of illness (e.g. Recovery Colleges)
- ✓ Work with service users to co-produce new services (e.g. Peer Support workers)
- ✓ Work with service users on issues to do with improving quality and outcomes
- ✓ Build staff resilience
- ✓ This will increase job satisfaction, improve morale, reduce sickness/absence, reduce incidents, etc.
- ✓ It will also allow many staff to do what they have been wanting to do for years!

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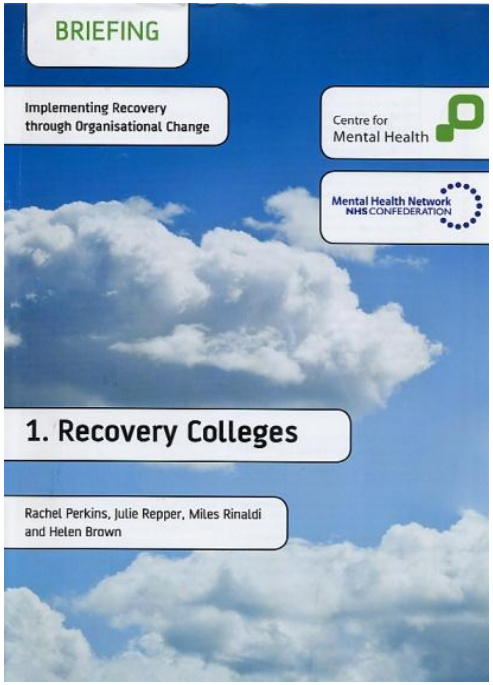
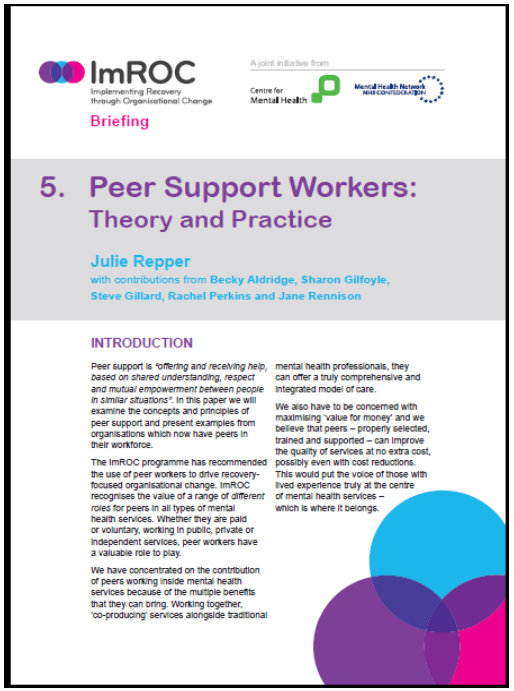
4. Develop Recovery Skills in the Workforce

Peers as educators & peers as staff

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Briefing

5. Peer Support Workers: Theory and Practice

Julie Repper

with contributions from Becky Aldridge, Sharon Gilfoyle, Steve Gillard, Rachel Perkins and Jane Rennison

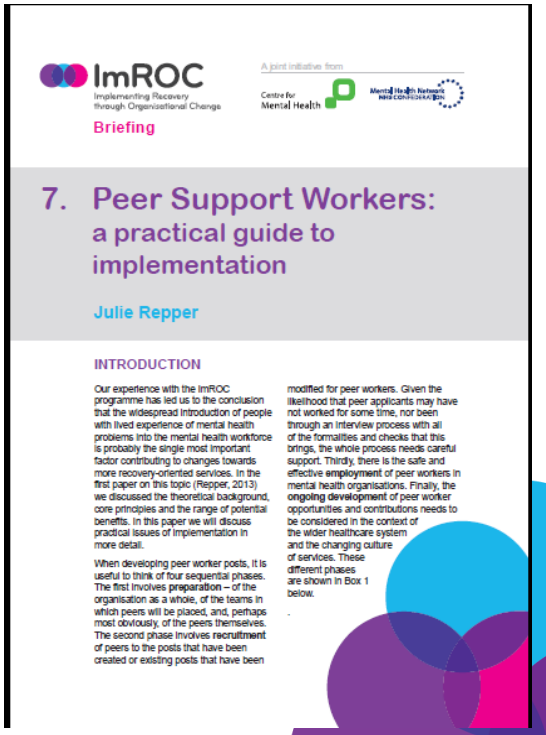
INTRODUCTION

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

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

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

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

7. Peer Support Workers: a practical guide to implementation

Julie Repper

INTRODUCTION

Our experience with the ImROC programme has led us to the conclusion that the widespread introduction of people with lived experience of mental health problems into the mental health workforce is probably the single most important factor contributing to changes towards more recovery-oriented services. In the first paper on this topic (Repper, 2013) we discussed the theoretical background, core principles and the range of potential benefits. In this paper we will discuss practical issues of implementation in more detail.

When developing peer worker posts, it is useful to think of four sequential phases. The first involves **preparation** – of the organisation as a whole, of the teams in which peers will be placed, and, perhaps most obviously, of the peers themselves. The second phase involves **recruitment** of peers to the posts that have been created or existing posts that have been modified for peer workers. Given the likelihood that peer applicants may have not worked for some time, nor been through an interview process with all of the formalities and checks that this brings, the whole process needs careful support. Thirdly, there is the safe and effective **employment** of peer workers in mental health organisations. Finally, the **ongoing development** of peer worker opportunities and contributions needs to be considered in the context of the wider healthcare system and the changing culture of services. These different phases are shown in Box 1 below.

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5. Make role models visible

- Choose prominent physical locations for new developments - e.g. Recovery College at CNWL
- Take on difficult challenges - e.g. reducing control and restraint on acute wards.
- Engage Comms. to publicise achievements – pictures, not words

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6. Amplify the power of consumers - Not just *'involvement'*, but '*co-production*'

What *co-production* is	What *co-production* isn't
✓ Recognising people as assets, not just problems	X Tokenistic 'consultation'
✓ Genuinely valuing the contribution that people who use services can make to improving them	X Volunteering
✓ Building trust and mutual respect through promoting reciprocity, e.g. through the Learning Sets	X User-led services (may be good, but not co-production)
✓ Building on existing, local 'social capital' (personal and community networks)	X Centrally driven policies. Trying to build networks from the inside (hospital) > outside (community)

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7. Evaluate success

(Shepherd & Boardman, '*Measuring Quality and Outcomes*', in press)

Suggested outcome indicators at an <u>individual</u> level:

- ❑ Improved experience of care (e.g. INSPIRE)
- ❑ Achievement of personal goals (e.g. GAS)
- ❑ Improved subjective recovery (e.g. QPR)
- ❑ Achievement of socially valued goals (e.g. ASCOF, Social Inclusion Web)
- ❑ ? Reduced service use (e.g. inpatient admissions, use of MHA)

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What about service-level evaluations?: (a) Recovery Colleges

Limited evidence, but Rinaldi et al., (2012) SW London, reported on over 1000 students attending courses in 2011/12 (44% with a diagnosis of schizophrenia). 62% completed more than 70% of the courses enrolled for.

- 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 (CMHTs)

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(b) Peer Support workers

Reasonable amount of outcome evidence (Repper & Carter, 2011) but generally not of a very high quality (Pitt et al., 2013). Nevertheless, services with peers consistently show superior outcomes compared with services without peers re:

- **Benefits for service users**
  - ✓ increased empowerment
  - ✓ increased problem-solving skills
  - ✓ improved access to work and education
  - ✓ more hopeful
  - ✓ more friends, feel more accepted

- **Benefits for peer workers -** *'I work hard to keep myself well now, I've got a reason to look after myself better……. It's made a real big difference'.*

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In addition, there are also benefits to the organisations from having peers in paid positions

- Mental health services always contain staff with low expectations of what service users can achieve (I've been there myself). This is '*institutional stigma*'.
- Peers in the workforce can effectively combat this kind of stigma, providing living examples of how service users and staff can work together, respecting each other's expertise, creating **new understandings** and **new expectations**
- Mental health organisations also contain inherent discrepancies in **power.** These are reinforced by a narrow adherence to a therapeutic model. Giving up power creates anxiety and (often) reinforces the need to **control**.
- Peers in the workforce demonstrate **how power and control can be shared** in a positive way.

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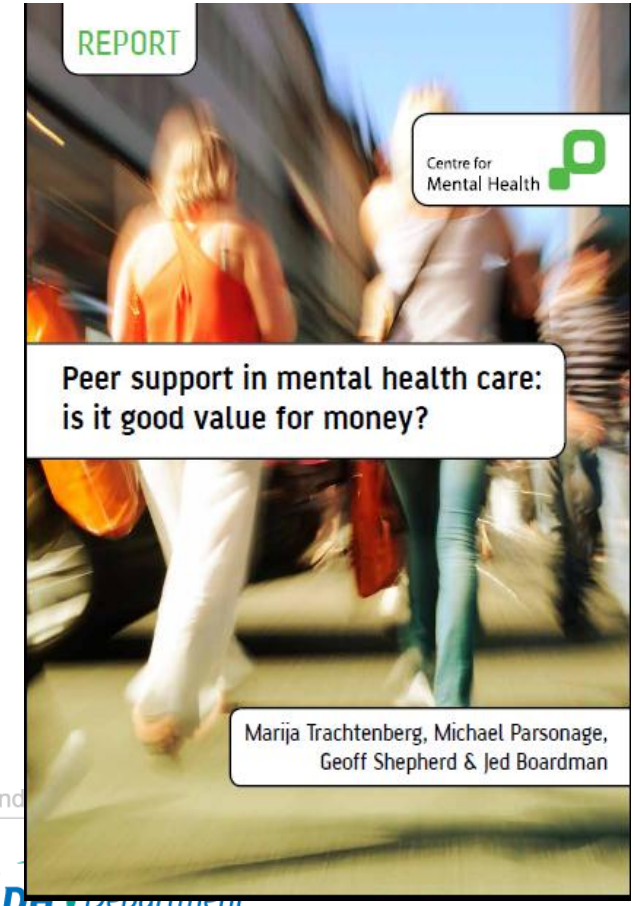
What about cost-effectiveness?



- Selected 6 controlled trials, 5 US + 1 Australian
- All provided data on impact of *adding* trained peer workers to existing inpatient or community teams
- Benefit/cost ratios calculated for using current NHS prices for workers and bed days
- In 4/6 studies ratios extremely positive (2.5–8.5 :1)
- In one study negative (-1.3) and in the other it was slightly less than 1 (+0.7)
- Nevertheless, overall weighted average (taking into account sample size) **> 4:1**

End

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So, could services which support recovery produce:

- **better outcomes for service users,**
- **benefits for those delivering the services (staff and service users)**
- **benefits to the organisation**

and …….

- **be better value for money?**

That would be a powerful combination

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Thank you

For further information contact

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